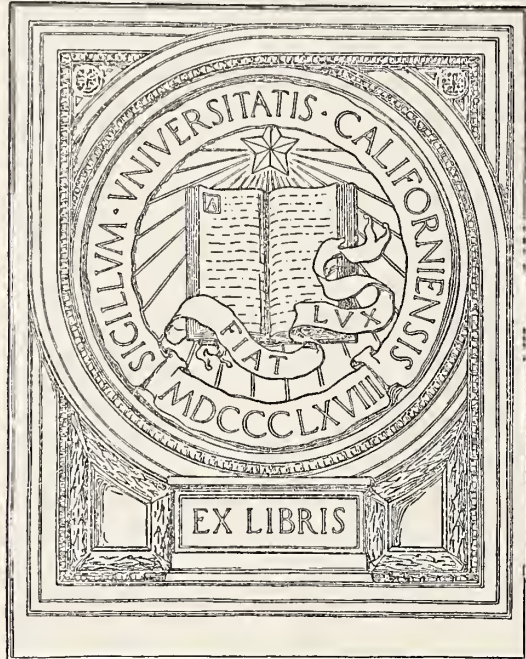
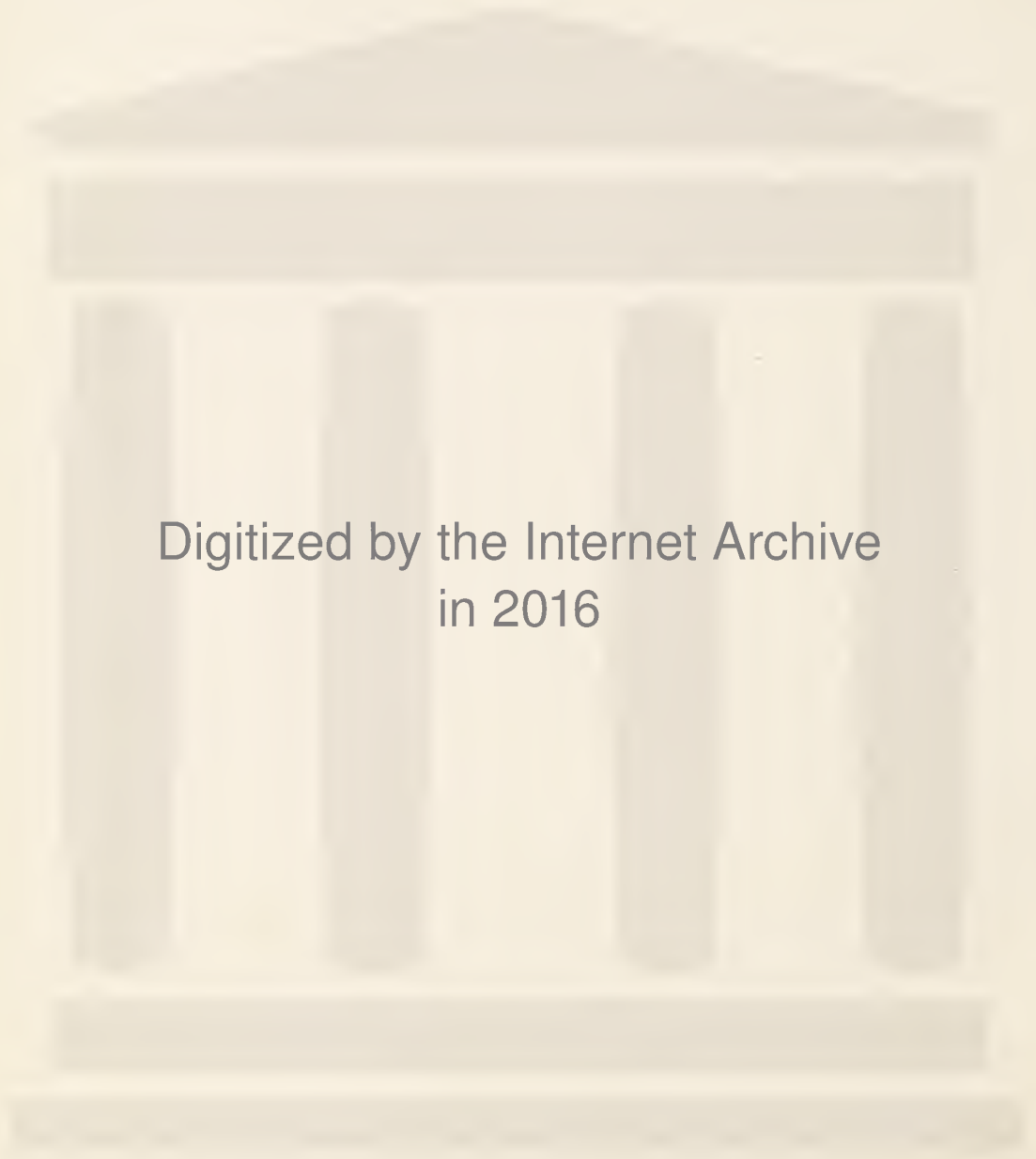


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Journal OF THE MEDICAL ASSOCIATION OF GEORGIA

Published Monthly

Edited for the Association Under the
Direction of the Council of the Association

Established 1911

EDGAR WOODY, JR., M. D., EDITOR

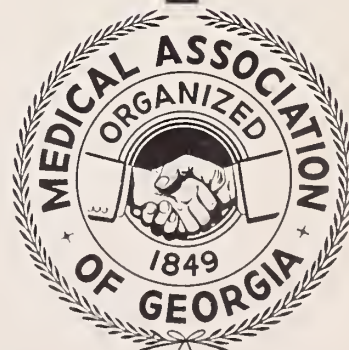
Subscription Rates: \$5 a Year, \$1 a Single Copy

Volume 45

January-December, 1956

MEDICAL ASSOCIATION OF GEORGIA

875 West Peachtree, N.E., Atlanta



JANUARY • 1956
VOL. 45, NO. 1

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Journal

OF THE
MEDICAL ASSOCIATION OF GEORGIA

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With St. Valentine's Day less than a month away, the *Journal* sends to each of its readers this valentine by Ted F. Leigh, M.D.

103251

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Re-education in the Treatment of Psychoneuroses

WILLIAM B. TERHUNE, M.D., New Canaan, Conn.

RE-EDUCATION, AN APPROACH to the treatment of the psychoneuroses is a process of physiological and psychological re-integration. It produces permanent results rapidly. It has been developed by psychiatrists and internists and incorporates medical, psychological, and psycho-analytical principles into an eclectic and flexible method of treatment. Physicians who employ this directive form of therapy must understand the physiological, psychodynamic, and sociological factors of emotional illness. If re-education is to be effective, it is absolutely essential to have the cooperation of patients who acknowledge the need for help and who are ready to accept directive treatment.

In directive psychotherapy the physician has an empathetic approach; makes the patient comfortable; gives his full attention; establishes rapport; encourages ventilation; teaches re-education; lessens guilt and anxiety; uses suggestion; gives support and helps the patient find new goals and ideals.

The emotionally ill patient is an apprehensive tyrant, surrounded by defensive and offensive mechanisms. Life has backed him into a corner, and if anyone tries to help him, he either cries or snarls. He is at the mercy of his emotions, since intelligence has ceased to function and ideals are unused. Psychological re-education overcomes this tyranny while permitting the patient to surrender with honor.

The psychoneuroses show the best response to the re-educational approach, yet this method is helpful to many patients suffering from psychotic as well as organic illness. Patients with definite psychotic personalities, without active psychosis, function fairly well after re-education with no further treatment. Most people who have recovered from a psychosis

should be re-educated to remove the scars of illness and prevent recurrence.

Factors Continuing the Psychoneuroses

It is impossible to enumerate in a few words the causes of the psychoneuroses. The many factors vary in different people under different conditions. The patient seldom reveals all of the causes of his psychoneurosis; usually he keeps one or two up his sleeve. This is not because they are not within his conscious knowledge—he knows what they are, but his ego would be shattered by revealing them. Re-education enables a patient to maintain his dignity; keep some things to himself and still get well. And this is good, since confession and deep insight make some people worse instead of curing them.

There are a few common denominators in the psychoneuroses that explain why re-education is effective: namely, basic fear (with accompanying guilt), ignorance, unresolved conflicts, secondary gains of illness, failure to accept “either-or”, mistaken philosophies, and absence of practical goals and ideals. Psychoneurotic patients are uniformly apprehensive, sensitive individuals who use poor judgment and live by inefficient techniques.

Fear is the greatest single cause of nervousness. The psychoneurotic's apprehension is inherent and fundamental—it never completely subsides, and the patient must learn to live with it. These patients are born with great basic apprehension which will be theirs until they die. They must accept fear and use it as the stimulus to courage. Not understanding the nature of their symptoms, and being ignorant of fundamental psychological principles, they exaggerate and misinterpret their illness. Re-education teaches the patient to deal with basic fear, dispels ignorance, and inculcates techniques of adaptation which help the emotionally handicapped and inefficient person to be successful.

Other factors contributing to the psychoneuroses

The author is Medical Director, Silver Hill Foundation for the Treatment of the Psychoneuroses, New Canaan, Connecticut; Associate Clinical Professor of Psychiatry, Yale University School of Medicine.

are faulty techniques of living, mistaken philosophies, absence of goals, and inability to find compensations. Unresolved conscious conflicts prolong emotional illness. A patient often knows what is upsetting him, but is unwilling to make definite decisions. Re-education shows him how such unresolved conflicts cause illness and demand definite clear-cut decisions of conflictual material. It also devaluates the secondary gains of illness by giving the patient impetus to recover.

Directive Re-Education

In short, re-education is a directive form of treatment which helps the psychoneurotic patient to overcome fear, displace ignorance with knowledge, adopt better techniques of living, and develop a sound philosophy. It destroys the secondary gains of illness, resolves emotional conflicts, reduces inefficiency and maladaptiveness, and directs the patient toward goals and ideals conducive to a useful life. The re-educational approach puts sex in its proper place—good when it is part of a good life, and seldom *per se* a cause of illness. We do not believe that repressed anger causes sickness, and we know that it is usually a mistake to *express* anger. Anger and fear are the most destructive forces in life, and the only antidote for them is love.

Method of Procedure

The success of all psychotherapy depends upon the relationship between doctor and patient. The physician must understand the patient, comprehend his preferences and prejudices, estimate his assets and liabilities, and discern his mental mechanisms. He must gauge the patient's physical capacities, intelligence, and sensitiveness, and also be aware of his emotional reactions. The physician must know the patient's cultural background and his major life experiences, be able to measure his ability to withstand strain, sense quickly the appropriate approach for a particular patient, and immediately inspire him with the belief: "Here is a doctor who recognizes that I am a worthwhile person and is sincerely interested in helping me." Confidence in the doctor gives him confidence in himself. The doctor is the bridge over which the patient crosses to find belief in himself, in others, and in life. Therefore the physician encourages the patient to lean on him for support, comfort, and friendship until he regains his own self-esteem and confidence. The psychoneurotic patient is unusually absorbed in self; he thinks of friends in terms of what they do for him. The doctor teaches him that friendship is an opportunity for service to others, forgetting himself and thus enriching his personality.

The first step in re-educational treatment is the taking of a therapeutic medical history. Through penetrating, significant questions, the doctor elicits important information and expertly leads the patient

to reveal the clinical picture, unobstructed by irrelevant and trivial details. The height of the art of eliciting a therapeutic history is to help the patient reach sound conclusions and find answers for himself. Successful re-education starts with the first interview. The way a medical history is taken tells most patients whether or not they are in the hands of a competent physician; it tells all psychoneurotic patients whether they are dealing with a "softie," a "smoothie" or a *doctor*. Next, a thorough physical examination performed by the physician himself convinces the patient that he has come, not to a philosopher, preacher, clinical psychologist, or "medical swami," but to a scientific physician. The third step in treatment is the doctor's therapeutic summation of the situation to the patient. On the basis of the history, physical, neurological, psychological, and laboratory findings, the doctor makes a clear-cut diagnosis, and tells the patient what it is (with none of the hocus-pocus of taking him on for a month's "evaluation"). The diagnosis is a full statement of what the doctor sees as the patient's problems: physical, emotional, spiritual, and situational. If the doctor cannot do this after a few days of intensive study, I advise the nervous patient to get a doctor with more knowledge and experience.

After diagnosis the doctor explains the nature, purpose, and plan of treatment. This is influenced by *how much* the patient can be helped and the time available for treatment. In re-education, the timing is as important as it is in surgery. The good psychiatrist does not drift and fumble; he knows what he is going to do, how, and when.

The patient is placed on a regime or daily schedule. If his home life or work is aggravating his illness, a few hours a week in the doctor's office will do a very sick person little good. It is axiomatic that the nervous patient under treatment will get worse if he does not quickly get better. If the patient cannot rapidly accept or alter his reactions to his situations, he must be placed temporarily in a therapeutic environment. This should not be a closed hospital or the psychiatric ward of a general hospital; both are contraindicated for the psychoneuroses. The ideal milieu is a psychiatric rehabilitation center where there are a relatively small number of patients. It helps to be with other psychoneurotics who are getting well. I am opposed to treating psychoneurotics in a mental hospital and in sanatoria where nurses in uniform baby the patients. While under treatment a patient must never discuss symptoms with anyone except the doctor.

In brief, procedures followed in re-education include: taking a therapeutic medical history, giving a thorough medical examination, telling the patient the diagnosis, and planning the treatment.

After the physician has taken a therapeutic history (not too long), completed the medical examination, made a preliminary diagnosis, outlined a plan of treatment, and decided upon the milieu for treatment, *didactic re-education is the next and most important step*. The doctor explains what re-education consists of and what is expected of the patient in learning it. He must cooperate while the physician takes full responsibility of directing treatment. Never compromise with a neurosis or a neurotic.

Fundamental Therapeutic Principles of Re-Education

These following psychological principles are the basis of psychiatric re-education:

Obtaining emotional release through limited ventilation, resulting in empathy and wholesome rapport in the doctor-patient relationship, while avoiding the danger inherent in too much ventilation.

Development of self-confidence—physical, mental, and social—through constructive suggestion and support.

Stimulation of latent ability through use of intelligence and acquisition of skills. Everyone has enough ability to acquire one or more skills.

Substitution of knowledge for ignorance, through didactic teaching of the adjustive mechanism, use of the mental tools of adaptation, self-discipline.

Establishment of a balanced life under a regime of work, play, exercise, and rest, regulated to suit the individual's need. Regimentation makes for efficiency.

Encouragement of adequate social relationships and cultivation of new interests, such as appealing hobbies.

The healthful use of constructive self-suggestion.

Spiritual re-orientation; the defining of new purposes and goals in life; the importance of the ideal of unself-seeking service efficiently rendered.

It takes a doctor two years to acquire the effective methods of teaching these principles and to learn the answers to the usual life problems. The principles and techniques have to be *actively* taught; merely exposing a patient to them does no good. Unless the patient who is taught these ideas believes in them and uses them, the psychological principles half-learned and half-used do harm. The psychoneurotic has a tendency to pick up medical information and use it to fortify his illness. I find that many psychoneurotic patients who have been unsuccessfully treated by psychiatrists have been hopelessly "psychiatrized," but even for some of these, re-education successfully breaks up the adhesions.

Teaching Re-Education

Re-education must be *taught* by the doctor, who finds a way to place it permanently in the patient's

mind so that it is employed automatically until it becomes as second nature as breathing. Through the neutral process of re-education there is an opportunity for interchange of ideas; the doctor and patient come to know one another, and the patient is flattered by having his intelligence valued by the doctor. During the process of didactic re-education, the doctor and patient temporarily put aside sickness and psychiatric jargon while they think in terms of health.

Re-education has this advantage over every other form of psycho-therapy; there is no long "waiting period" to attain encouraging results. Intelligence begins to function immediately and results are obvious. The patient sees there is something definite *he* can do about his illness and problems; he learns principles and techniques which he comprehends and at once uses effectively. We have worked out a definite outline of psychological re-education and have incorporated these principles in re-educational pamphlets, which patients take home and consult for years. The pamphlets are taught one at a time, the teaching adapted to each patient's need and degree of perceptiveness. The patient learns the facts of personal mental hygiene in three ways:

First, he is tutored by the doctor, who explains each step in re-education *before* the patient reads it.

This means that doctors who can teach are most successful in treating these patients.

Second, the patient studies the printed material two hours daily, learning it *academically*, *not* applying it to his problems.

The printed word still carries conviction which the spoken word lacks.

Third, the patient tells the psychiatrist what he has learned, both verbally and by writing it out.

Group seminars for discussing interpersonal relationships are held concurrently with the didactic re-education. The fact that these seminars are appropriate for the whole group makes the patient realize that he is not "alone" in his problems, not "different" from other people. He learns that about 80 per cent of the people in the world are at one time or another seriously emotionally handicapped. He comes to understand that neurosis is the income tax of civilization and that re-education reduces the tax.

The application of re-education requires four weeks of daily one-hour interviews with the doctor, supplemented by the patient's studying two hours daily. Concentration on this didactic material keeps the patient from dwelling on his symptoms and troubles, gives him solutions to many of his problems, and breaks up his habit of thinking of himself as a sick man. Since the material is universally applicable, he begins to see that his problems and his life situa-

tions are no more difficult than those of the average person.

Once equipped with information and techniques for handling his problems successfully, he feels superior and believes that he can now get along better. Since he no longer needs a neurosis, he allows the doctor to remove it. This is an important point. The secondary gains of a neurosis are so great, the patient is so afraid, and perhaps has become so neurotically tyrannized that the psychiatrist often has to forcibly deprive him of his neurotic crutches. "Give me your stick! Walk alone and erect!"

During the remaining two to three weeks devoted to treatment, the patient discusses unsolved difficulties and practical techniques of dealing with them. Throughout treatment the psychiatrist has worked with the family to secure their understanding cooperation and has kept them informed about the patient. The doctor never treats a patient who will not let him see the family. The patient should not be isolated from family and friends, but should be kept near the firing line—safe, but in sound of the guns—if he is ever to get back into battle.

When trial visits home have gone well, treatment is completed and the patient goes back to work—not on a "trip to Florida." Frequently the neurotic patient must literally be *sent home*. The treatment milieu must not be allowed to become a refuge. Once the doctor is confident he can carry on, it is better to send him home and have him fail—even come back and take another shot at it—than to keep him too long. Some doctors are lazy about this, or perhaps afraid the patients will not do well, and so keep patients too long. In my opinion, better a short period of treatment for the neurotic than too long. Send him home and to work on a carefully thought-out written schedule of work, play, exercise, and rest, with new interests which will make him successful. It is to be hoped he has learned that no one is ever going to get all he wants in this world—unless what he wants is to devote his life to unself-seeking service. Only by serving others without expectation of recognition does any human being learn the meaning of love—the greatest reward on earth and perhaps in heaven.

Systematic Follow-up

When the patient returns home he is like a recently graduated medical student who has learned basic principles and techniques, but needs practice under supervision. During the first six months the doctor should keep in touch with the patient by visits, letters, and telephone. We must not be afraid that he will misinterpret our motives; if necessary we must force after-care on him. We consider that the re-educational treatment of a psychoneurotic patient is

a life-long adventure in friendship in the fullest sense of that term, not merely an isolated medical experience.

Results

Results obtained through re-education of psychoneurotic patients vary according to the nature of the illness, the individual, his ability to withstand strain, and the circumstances of his life. Experience enables the physician to evaluate the possibilities of accomplishment with each patient, justifying prolonged psychotherapy for some and saving others expensive and unrewarding treatment. Most psychoneurotics can be cured; some helped expeditiously must have further treatment from time to time.

A study of 20 thousand clinical records shows that through re-education of emotionally ill patients:

The acute psychoneuroses are cured. Fifty per cent of chronic psychoneuroses are relieved.

Thirty per cent of the remainder are greatly helped.

Pre-psychotic personalities are strengthened.

Conclusions

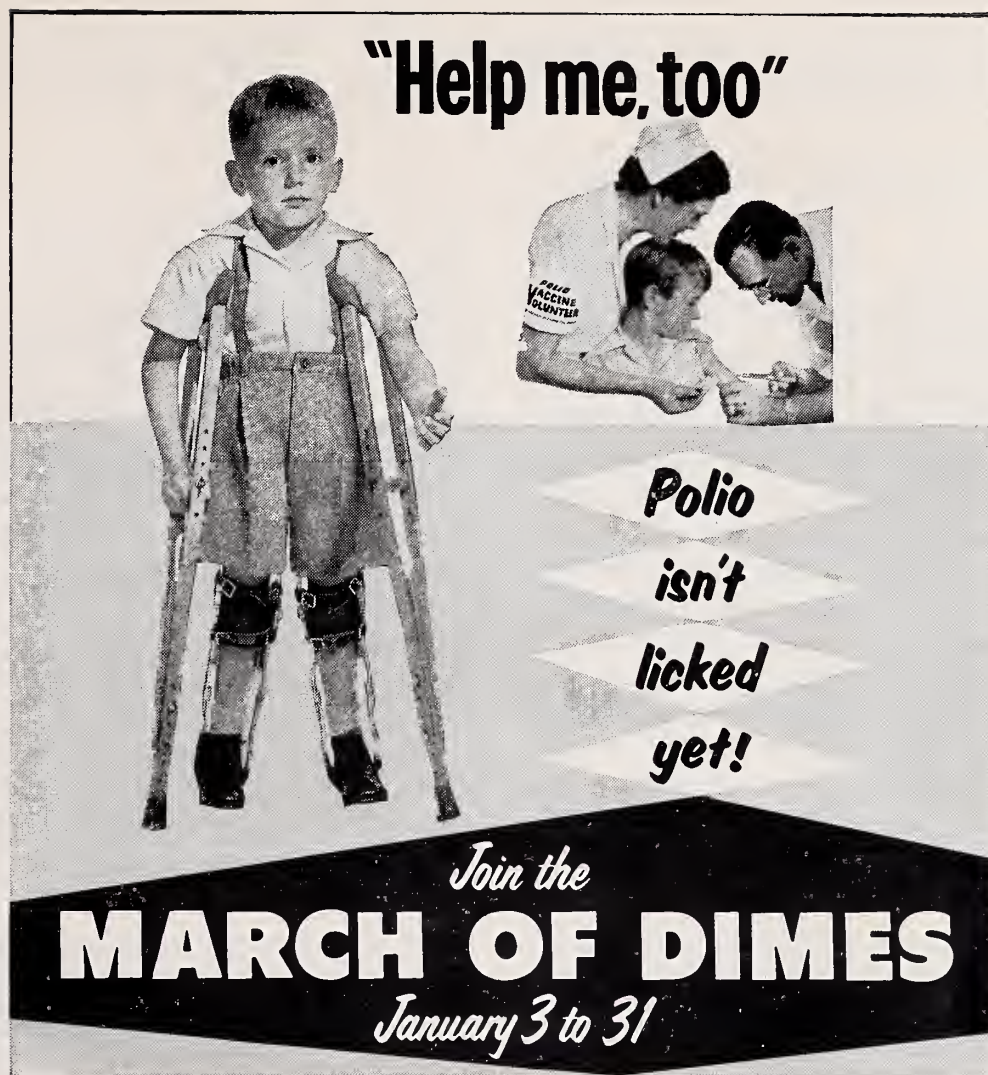
Psychoneuroses are psychosomatic disturbances induced or enhanced by relevant emotional strain, occurring in individuals with constitutional, experiential, or environmental predispositions. The illness is continued by fear, ignorance, and unwillingness to relinquish secondary gains of illness.

The majority of emotionally ill patients are not as interested in what makes them sick as they are in getting well. They must understand the precipitating factors of their illness to prevent recurrence. The ability to live successfully is dependent upon maturity of personality and character, on an understanding of the environment in which one lives, and a good technique of adjustment. The majority of man's experiences are common to all human beings: re-education teaches proved methods of adapting to these experiences and situations.

Re-education considers the patient's physical and psychological needs, imparts information which enables him to solve many of his problems, somewhat prevents future emotional complications, and henceforth enables the patient to manage his life wisely. It helps him find new purpose and goals in life by teaching that happiness is a by-product of intelligent usefulness and service.

The one purpose of directive re-education is to restore a worthwhile individual to usefulness and, incidentally, to happiness. This the doctor accomplishes by precept and example, bearing ever in mind Sallust's belief: "That learning is of small repute with me which nothing helped the teachers themselves." Patients need to be able to trust their doctors. Physicians must see that they are not dis-

(Continued on next page)



Re-education in the Treatment of Psychoneuroses (cont.)

appointed in what may be their first venture in friendship.

Psychotherapy is an integral part of medicine, consciously or unconsciously employed by every physician in the treatment of every patient. It comprises one-third of the therapy in most cases, the total treatment in many. Re-education is a rational, practical method of psychotherapy which every physician can learn to use skillfully, thereby enhancing enjoyment of his profession as well as increasing his usefulness and success. Psychoneurotic patients are many and psychiatrists are few. If all who need treatment are to receive it, they must rely upon practicing physicians who have opportunity to diagnose and treat psychoneuroses before they are full-blown.

One physician who was being trained in the principles and techniques of re-education said: "It is all so wholesome and such damn good common sense that even the psychiatrist has faith in it." This probably helps most of all.

In my opinion we do not need more psychiatrists;

we need more doctors who will substitute a little personal mental hygiene for a shot of penicillin—or perhaps inject them both at the same time.

*Silver Hill
Valley Road*

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Peptic Ulcer in Meckel's Diverticulum

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IN 1815 JOHANN FRIEDRICH MECKEL described a diverticulum which has come to bear his name. He stated that it was an anomaly of the terminal ileum associated with the omphalomesenteric, or vitelline, duct. Since its description much has been written about this interesting anomaly. Sanderson and Barrett²¹ estimated that it occurs in about one to three per cent of the population, with men leading two to one. In the experience of Penberthy and Benson¹⁸ acute massive hemorrhages occur mainly in infants under two years of age, but in rare instances they are observed in the late teen age group and even in adults.

The presence of gastric mucosa in a diverticulum capable of secreting gastric juice was established by Hudson¹¹ in 1933. He pointed out that erosion or ulceration with the production of definite peptic ulcer, capable of bleeding and perforation, was a possibility. Deetz⁴ in 1907 first reported the peptic nature of the ulcerations in Meckel's diverticula.

Greenblatt, Pund, and Chaney⁷ advanced the most acceptable theory to account for the heterotropic tissue, pancreatic tissue, and gastric and duodenal mucosa in these diverticula. They believed the vitelline duct has some slight function in early fetal life, associated with digestion, and that the endodermal cells lining the primitive intestinal tube possess the potentiality of developing into any glandular element of the fully developed gastrointestinal tract. Retrogression normally takes place as soon as the digestive functions end in early fetal life, with complete obliteration and disappearance of the duct. If this regression is retarded for any reason, a vestige of the heterotropic tissue remains and develops. This is known as the dysembryoma theory.

Diagnostic Role of Miller-Abbott Tube

Use of the Miller-Abbott tube to determine the site of bleeding in the small intestine is not a new procedure. It has been described in the literature several times.^{1 23 24} As was pointed out by the author in 1948,²⁴ it is a most effective means of locating a bleeding area. The tube is passed into the stomach, and samples of its contents are aspirated and tested for blood. When none is found, the tube is passed un-

der the fluoroscope into the duodenum, and samples are taken and tested in the first and second portions of the duodenum. Mercury in the bag of the Miller-Abbott tube greatly facilitates passage. When the duodenum is passed, air or water is put into the bag, and the tube is advanced six inches every 30 minutes; samples are taken just before the next advancement.

When blood is first encountered, a roentgenogram is taken, and from this, as well as from the length of tube inserted, the approximate location of the lesion can be determined. Except in the most massive hemorrhage, in which this method is not practical, reflux of blood does not extend more than six to 18 inches. It is often a comfort to have this determination prior to surgery because frequently by the time a patient is prepared for surgery the hemorrhage has stopped, and looking for the site of former bleeding when it is quiescent is far from satisfying.

In the case reported here the lesion would have been found readily without this procedure, but because of the age of the patient and the large amount of blood passed in the initial stage, all the physicians who saw him thought that the more information at hand before operation, the better would be his chances of survival. The correct diagnosis was made prior to surgery.

Report of Case

J. M. P., a white youth, aged 16, was admitted to the hospital on Nov. 21, 1952. On the night before admission he had experienced slight cramping pain in the abdomen. During the day of admission, however, he had felt well, had eaten normally, and had attended school. About 5:00 p.m. a dull, cramping pain developed in the lower portion of his abdomen, and a stool contained a large quantity of dark blood. He vomited on the way to the hospital, but there was no blood in the vomitus.

There was a history of colitis and protrusion of the rectum in infancy, appendicitis at the age of six, rheumatic fever with several months of bed rest at the age of nine, and tonsillectomy a year later.

The only significant findings on physical examination were slight tenderness in both lower quadrants of the abdomen and bright red blood present in the rectum. Urinalysis gave normal results. The hemoglobin estimation was 10.5 Gm. (Sahle), the red blood cell count was 3.17 million, and the white blood cell count was 9,800 with a normal differential count.

On November 22 sigmoidoscopic examination disclosed no lesion, but this was not entirely satisfactory

Appreciation is expressed to Dr. Henry H. Tift, Dr. Thomas Harrold, and Dr. Max Mass, all of Macon, for their invaluable consultation and assistance in this case.

Miller Abbot Tube Determines Site of Massive Hemorrhage

because of the large amount of old and fresh blood encountered. The following day there were four large tarry stools with no evidence of bright blood, and there was no blood in the vomitus. Two pints of blood were administered. The bladder was distended. Because of inability to void on November 24, the patient was given glucose in water intravenously. Urinalysis on the next day showed a trace of sugar and of acetone. An attempt to pass the Miller-Abbott tube was unsuccessful because the patient was most apprehensive and not sufficiently cooperative.

On November 26 the hemoglobin estimation was 9.2 Gm., the red blood cell count 2.85 million and the platelet count 100,000. The Miller-Abbott tube was passed on that date. Following a second transfusion, the hemoglobin estimation on the next day was 11.3 Gm., and the red blood cell count was 3.14 million. The tube was well into the small intestine, but there was no evidence of blood.

On November 28 blood was aspirated. A roentgenogram (Figure 1) of the abdomen showed that the tip of the tube was in the terminal portion of the ileum. Four hours later it was in the transverse colon (Figure

2). A roentgenogram following a barium enema gave negative evidence.

At operation on that day, through a right pararectus incision, a large Meckel's diverticulum, $3\frac{1}{2}$ by five cm. in size, was removed. The pathologist reported ectopic gastric mucosa with ulceration and hemorrhage.

The patient made an uneventful recovery and left the hospital on the eighth postoperative day.

Summary

A brief review of the literature dealing with Meckel's diverticulum and complicating hemorrhage from it is presented.

The use of the Miller-Abbott tube in locating the site of bleeding in the small intestine is discussed.

A case is reported in which the Miller-Abbott tube was used to locate the site of bleeding in the small intestine, and a preoperative diagnosis of hemorrhage from a Meckel's diverticulum was made.

210 Doctors Building

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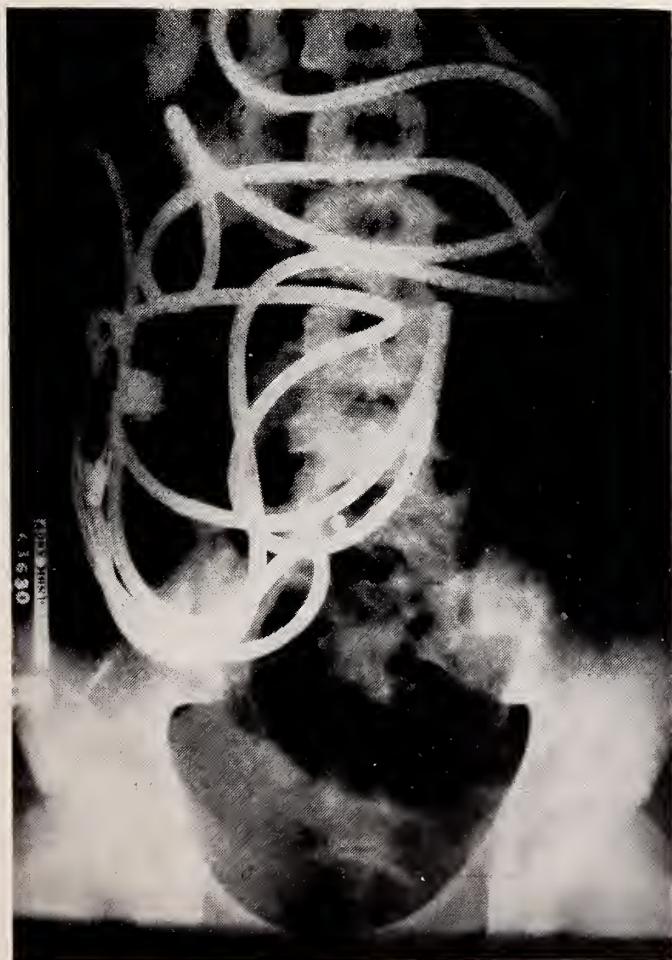


Figure 1

Roentgenogram taken when blood was first recovered from the Miller-Abbott tube. The tip of the tube is turned back and is in the terminal portion of the ileum.



Figure 2

Roentgenogram showing that the tip of the tube is still turned back and has passed into the transverse colon four hours after being in the position demonstrated in Figure 1.

Federal Medical Legislation

THESE ARE SOME of the medically-important issues that will be fought out in Senate and House:

1. Federal guarantee of mortgages on health facilities. The federal government would underwrite mortgages for hospitals, clinics and nursing homes, under certain conditions.

2. Federal grants for research facilities. The U. S. would make outright grants to laboratories, medical schools and clinics for building facilities for research in specific diseases.

3. Federal aid to medical education. The popular bill restricts the federal role to grants for building and equipment, with a financial incentive held out to schools willing to increase their enrollment.

4. Salk vaccine. Legislation authorizing appropriations for the purchase of Salk vaccine expires February 15. One issue is whether the federal government should continue the grants; more controversial is the question of whether the U. S. should move in to control the allocation and distribution of the vaccine.

5. Increases in federal appropriations for medical research. Over the last few years—since the National Institutes of Health came of age—Congress repeatedly has increased research grants over the amounts the Budget Bureau allowed Public Health

Service to request. This year the Budget Bureau may have to allow important increases to be requested of Congress.

6. OASI-covered persons could receive payments beginning at age 50 (instead of 65), if determined to be disabled. The bill containing this provision (H.R. 7225) passed the House last session by an overwhelming margin. It is now before the Senate Finance Committee.

The lop-sided House vote on disability payments may be discounted in part because of the parliamentary maneuvering by sponsors of the legislation. House members had only 40 minutes to debate this bill, and no opportunity to amend it. It was a case of accepting the whole bill—which contains a number of other social security liberalizations not of medical significance—or being politically damned as opposed to social security per se.

The American Medical Association maintains that the present expanding rehabilitation programs would be undermined by cash payments for disability, that the financial and other long-range aspects of the disability payments plan have not been thoroughly studied, and that the machinery for disability payments would inevitably project the federal government deeply into the medical care picture.

Peptic Ulcer in Meckel's Diverticulum (cont.)

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Tachycardias Due to Allergy

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CARDIO-VASCULAR manifestations of allergy are not new. Rheumatic heart disease has been thought by some to be an allergic reaction to streptococci. Myocardial lesions have been described which were thought to be due to an allergy to drugs. Waugh¹ in 1952 reported a case showing myocardial lesions that he attributed to sensitivity to penicillin. However, a review of the literature reveals no instances of tachycardias due to allergy with the exception of one report. Russek² and associates recently reported a case of tachycardia, with electrocardiographic changes, which was due to cigarettes and which disappeared when the patient stopped smoking. Tachycardias may at times be crippling even though there is no organic heart disease; the fact that these may be due to allergens other than tobacco apparently has not been recognized. The following cases are those in whom the tachycardia was due to an allergy, and the removal of the allergen produced a cure.

Case 1

This patient was a married woman, 38 years of age, who was first seen in 1944. She stated that she had a partial thyroidectomy three years before for what was apparently a toxic thyroid. While convalescing from the operation she began to drink about one quart of milk daily to give her more strength. She continued to have weakness and a rapid pulse rate, and at the time I saw her, she had been bed-ridden for a period of three years. On examination she was found to have a constant pulse rate of 150 but no evidence of organic heart disease. It was felt that she was probably allergic to milk. She was told to stop drinking milk and was also advised to get out of bed. When examined one week later she was found to have a pulse rate of 110. Since her pulse rate remained this fast hyperthyroidism was suspected. This suspicion was confirmed by a BMR of plus 37. After X-ray treatments to her thyroid, her pulse rate slowed to 80-90. She was then told to drink one glass of milk with each meal and report back in two days. At this time she was found to have a pulse rate of 120. The rate slowed to 88 again when the milk was omitted and she has had no further trouble.

Case 2

This patient was a 60 year old dentist who was first seen in 1945 at the request of an insurance company. He had applied to the insurance company for total disability payments and was referred to the author for a cardiac evaluation. He stated that he had had an attack of coronary thrombosis in 1935. He did well after this for a period of 9½ years with the exception of occasional attacks of palpitation. Six months before he

was seen by the author he had a severe attack of palpitation and was diagnosed as having paroxysmal auricular tachycardia. Following this he had not been able to work since standing produced weakness and tachycardia.

He gave a history also of migraine and hay fever since his youth. He was found to have a peptic ulcer 15 years previously and was drinking three quarts of milk daily.

On examination he was found to have a moderate degree of arteriosclerosis, but there was no evidence of organic heart disease. The electrocardiogram showed no evidence of previous myocardial infarction, which made the past history of coronary thrombosis questionable. His blood pressure sitting was 110/75. On standing there was a slight drop to 105/80 and an immediate onset of an attack of paroxysmal auricular tachycardia.

It was thought that he was allergic to milk, and he was asked to eliminate this from his diet. He reported over the phone 10 days later that he had experienced no further attacks of tachycardia since leaving off the milk. He was asked to drink milk with each meal and report whether or not this caused a return of his tachycardia. He was reluctant to do this but finally in the interest of science agreed to do so. He reported three days later that after taking milk with each meal he had no further attacks of tachycardia. After two days of taking milk, however, he had a severe attack of migraine, the first such attack he had suffered in over a year. By way of comment, it is of course common for an allergen to produce different manifestations at different times.

He has done well for the past 10 years and has remained at work. He has continued to eliminate milk from his diet and has had only two attacks of tachycardia. One of these came with a severe attack of migraine, and one came during a period of excitement when the house next door was struck by lightning. The fact that he still has rare attacks of migraine indicates that he is allergic to something in addition to milk, his attacks, however, have been infrequent.

Case 3

This patient was a boy, 15 years of age, who was seen in 1946. He was well until one week before admission. At this time he had an attack that was typical of paroxysmal auricular tachycardia. He had another attack five days later. On examination no evidence of organic heart disease was found. There was no history of allergy. He had been drinking about one quart of milk daily.

The elimination of milk from his diet produced a cessation of his attacks. His parents would not permit him to drink milk to see if the attacks would recur. However, four months later he drank milk on one occasion, and this was followed by an attack. He then remained free of attacks for a period of three months. At that time he had another attack and questioning revealed that he had

(Continued on next page)

Presented at the 105th Annual Session of the Medical Association of Georgia, May 1-4, 1955, Augusta, Ga.

Corporate Practice of Medicine

PHYSICIANS IN IOWA recently won a court victory of major national significance in contest with Iowa's non-profit hospitals. After a lengthy trial, involving the Iowa Hospital Association which brought suit against the State Attorney-General, the Iowa State Board of Medical Examiners, and the Iowa Association of Pathologists, the Court ruled that hospitals which employ doctors and profit from their services are guilty of the corporate practice of medicine.

By ruling in favor of the Iowa doctors the court supported the contention that service rendered by a physician in a hospital is, in fact, medical service for which the physician must directly bill his patient.

Furthermore the district judge added, any hospital specialist who allows the hospital to bill a patient for his services is guilty of fee-splitting. He conceded, however, that a hospital has the right to bill patients for laboratory services in the doctor's name,

thus serving, in effect, as his collection agent.

Iowa doctors, especially pathologists and radiologists, hailed the decision as a victory for private medical practice. The district court's decision has established a precedent which may affect salaried doctors across the nation who wish to be released from hospital ties.

In ruling that it is illegal for Iowa hospitals to employ physicians and charge patients for their services the court concluded more specifically:

— "That the work done by pathologist, radiologist . . . constitutes the practice of medicine.

— "That . . . the privilege of practicing medicine is a personal one requiring qualifications which cannot be met by a corporation.

— "That the plaintiff hospitals . . . have been engaged in unauthorized, unlicensed and illegal practice of medicine."

Tachycardias Due to Allergy (cont.)

eaten a large amount of ice cream that day. Since eliminating milk and ice cream from his diet, he has had no further attacks. It is of interest to note that he had a mild postural hypotension as did the dentist in the previous case.

Case 4

This patient, an unmarried woman, 35 years old, was seen in 1943. Her complaints were: choking sensations, palpitation, and nervousness. She had no history of allergy, did not drink milk, but smoked 10-12 cigarettes daily. No evidence of organic heart disease was found on examination, and there was nothing to account for her symptoms. She was treated with sedatives without any relief. She was seen over a period of years and was always found to have a tachycardia with a rate of 110-140. In 1944 a BMR was done and reported as plus 21. Following this she was given X-ray therapy to her thyroid with no relief of her symptoms. In 1947 it was thought that she might be sensitive to tobacco. She was asked to quit smoking although she had never smoked more than 12 cigarettes daily. This was followed by prompt relief of her symptoms. Her tachycardia which had persisted for years slowed to 90. She has had no further trouble since she quit smoking in 1947. This case is similar to the one reported by Russek² and associates.

Case 5

This case while probably due to an allergy was not definitely proven to be. This was a married woman, 53 years of age, who was seen in 1953. She gave a history that was typical of premature contractions. In addition to these, which were constant, she had several attacks daily of paroxysmal tachycardia. On one occasion she was taken to a hospital and a diagnosis of coronary thrombosis was made. I learned from the doctor who treated her at that time that she had no electrocardiographic changes of myocardial infarction but that his diagnosis was made on the history and clinical findings. He further stated that her subsequent course made him

doubt the accuracy of his diagnosis of myocardial infarction. She had no history of allergy, did not drink milk, and had quit smoking three months before at the suggestion of her doctor. She had been treated with quinidine and sedatives, and these drugs did not prevent her attacks. She was confined to her home, since she lost consciousness with some of her attacks she was afraid to venture out. Physical examination revealed no evidence of organic heart disease. Her electrocardiogram was normal with the exception of occasional auricular and ventricular premature contractions. Nothing was found on examination to suggest a trigger mechanism for her attacks.

Since this woman had not responded to any of the therapeutic measures she had been given it was thought that her attacks might be due to an allergy. In view of this she was given Chlortrimeton, four mg. t.i.d. She reported over the phone a month later that she had experienced no attacks after being on this drug and that she had resumed a normal life. At the time this paper was written she was again contacted. She reported that she took Chlortrimeton for a period of two months and then discontinued it. She has had no further attacks of tachycardia but is troubled with premature contractions at times. While this case does not prove anything I feel that her attacks were probably due to an allergy. If this be true she probably will have to resume taking Chlortrimeton in the future.

Summary

In conclusion, the above cases simply call attention to the fact that tachycardias can be due to an allergy. Also, that the removal of the allergen can result in a cure of this condition which at times can be crippling.

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Translumbar Percutaneous Antegrade Pyelography

As an Adjunct to Urologic Diagnosis

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THIS PAPER IS A RESULT of a few cases that have reminded the authors of a well-known fact, namely, that excretory and retrograde pyelography occasionally leave something to be desired in urologic diagnosis. Several cases have been seen in the last year when, due either to poor renal function or technical difficulties at the time of cystoscopy, evaluation of the condition of a kidney has been impossible. One such case in early 1954 recalled to mind some previous studies on what was at the time called "renal tap." Kapandji³ carried out these studies as early as 1949. Ainsworth and Vest¹ described the procedure in 1951. Weens and Florence⁴ also did some of these studies in Atlanta in 1953. Accordingly, we did our first percutaneous pyelogram. We were very favorably impressed with the simplicity of the procedure and the valuable information so obtained.

Now let us discuss in some detail the history, indications, contraindications, technique, and results of this procedure. We are indebted to W. E. Casey and W. E. Goodwin⁴ for the descriptive, if somewhat formidable, name "percutaneous antegrade pyelography." They, in turn, give credit to Dr. D. M. Davis² for the term "antegrade" as opposed to "retrograde" pyelography. We added "translumbar" to more accurately describe the procedure.

We have found this procedure of value primarily when dealing with moderate to marked hydronephrosis. Successful entrance by needle into a small renal pelvis is difficult if not usually impossible. The procedure should be limited in general to instances where other methods of diagnosis, such as excretory urography or retrograde pyelography, fail—due either to non-function and obstruction of the suspected kidney or to technical difficulty which precludes retrograde pyelography. In certain cases, when cystoscopy might be contraindicated, antegrade pyelography might, however, be the method of choice.

The technique has been well described by Florence and Weens and also by Casey and Goodwin. We

have made only minor changes in these two very similar descriptions. It is our practice to place a patient prone on an X-ray table and make a scout KUB film, this being done to show the position of the renal shadow in reference to the twelfth rib. The rib is then palpated and a puncture site is selected just under the rib in about the mid-scapular line, or sometimes a little lateral to this landmark, depending on the findings of the scout film. The skin around the proposed site is prepared with a suitable antiseptic solution. The skin is then anesthetized with one or two per cent procaine. Also the underlying tissues are usually infiltrated. Then an 18 gauge six inch needle (the same needle generally used in translumbar aortography) is passed through the skin and underlying tissue directly into the kidney, through the parenchyma and into the pelvis. After the kidney parenchyma is entered, we frequently aspirate gently as the needle is introduced further into the kidney substance. When the renal pelvis is entered, urine is drawn into the syringe. It is then known that a successful puncture of the renal pelvis has been made. At this time a minimum of 10-15 cc. of urine and sometimes as much as 30-40 cc. or more of urine is aspirated from the renal pelvis, following which radiographic media is injected directly through the needle into the renal pelvis. It is our policy to generally use the same media as commonly used in retrograde pyelographic studies. With the needle still in position, the antegrade pyelographic film is made, the needle being left in position in case the injection has been poor or insufficient media has been injected. If filling has been adequate, the needle is removed and, if desirable, a later film may be made. If one desires good filling down to the ureter, it is wise to wait an hour or so and make a follow-up film.

The following few cases demonstrate the usefulness of the procedure and some of the results.

Case 1

Mrs. G. W. P., aged 41 years, was admitted to the hospital January 1, 1954. Her present illness began 48 hours prior to admission to the hospital and consisted of a dull left flank pain, requiring no opiates, and followed by anuria the next day with subsidence of pain.

Her previous history was not significant although she gave a vague history of some right renal pathology 18 years prior to this time; however, this subsided and, with

Presented at the 105th Annual Session of the Medical Association of Georgia, May 1-4, 1955, Augusta, Ga.

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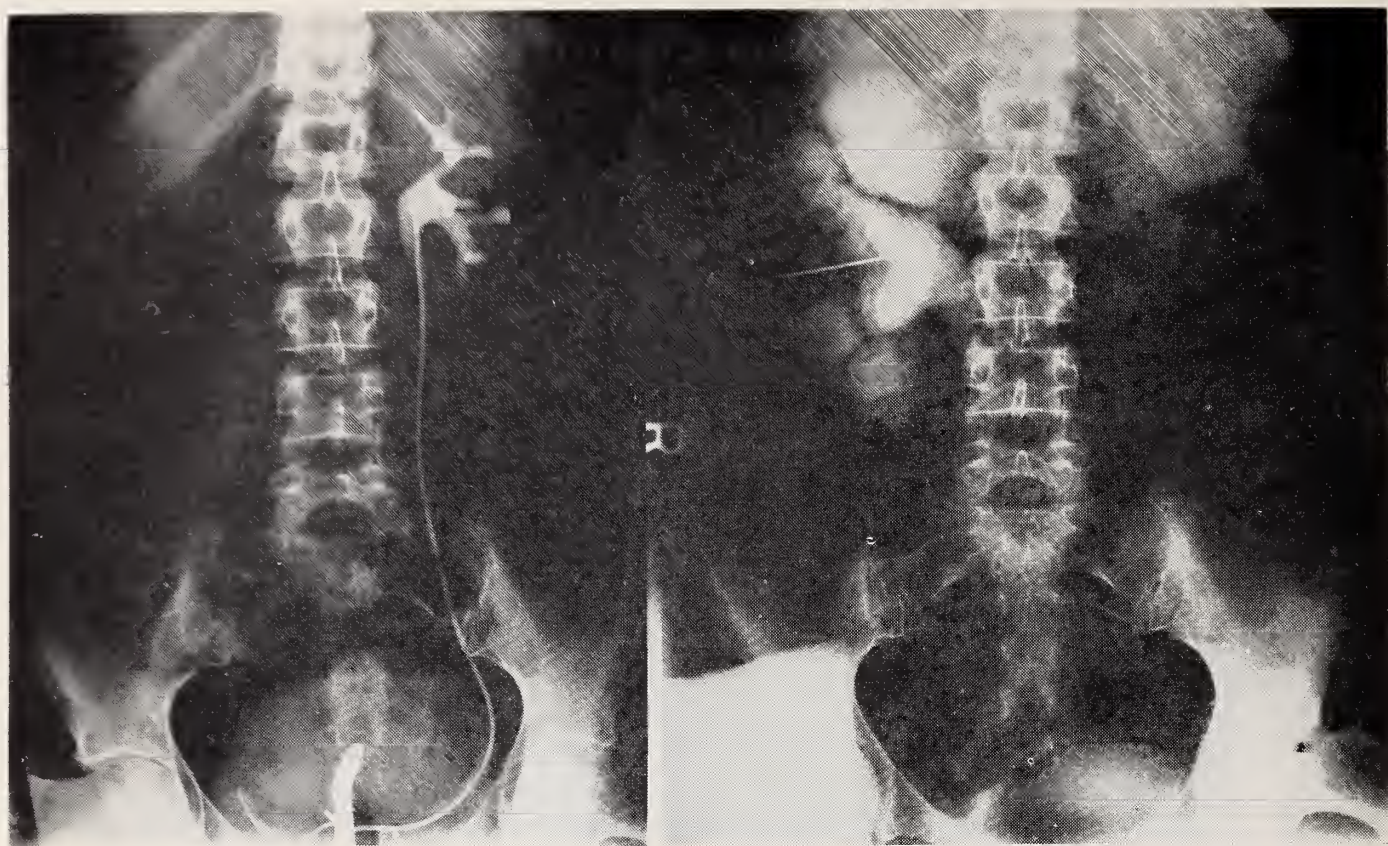


Figure 1

the exception of one episode of very mild hematuria, she had no other definite symptoms.

Routine physical examination revealed a normal temperature, pulse 110, blood pressure 190/110. Positive findings included a slightly enlarged heart and a palpable mass in the right flank which moved with respiration.

Her initial laboratory study showed a hemoglobin of 7.1 gm. with red count of 3.4 million. White count was 11,300 with slight shift to the right. Her electrolytes were thrown out of balance, and at the time of admission N. P. N. was 61 mg. per cent and creatinine 5.4 mg. per cent.

At this time we suspected that we were dealing with an oliguria due to a lower nephron disturbance in a patient with an undiagnosed mass in the right upper quadrant.

On cystoscopic examination the bladder was empty with the exception of a few cc. of almost pure blood. A catheter was passed up the left ureter to the region of the pelvis, but we had no success in passing a catheter up the right ureter, there being complete obstruction just within the orifice. Pyelograms were attempted but were unsuccessful. No media went up the right side, and apparently there was an obstruction in the upper ureter on the left by which the media would not pass. Following this procedure the catheter was left in place on the left side, and in 48 hours the urine output became adequate.

Phenolsulfonephthalein output was too low to expect to obtain any information through excretory urograms.

One week later the patient was recystoscoped, and a normal left pyelogram was made. At that time a small calculus was discernable in the lower calyx of the left kidney. Again we were unable to pass a catheter up the right side, and a percutaneous antegrade pyelogram was done showing a large hydronephrotic sac which was subsequently removed. (Figure 1)

Case 2

Mr. E. R. C., aged 75 years, was admitted to the hospital May 15, 1954, complaining of constant severe right lumbar pain of several weeks duration requiring Demerol frequently for relief.

He had had two trans-urethral prostatic resections elsewhere for carcinoma of the prostate and bilateral orchiectomy with some improvement.

Physical examination revealed a well-developed man, senile but alert and cooperative, not obviously acutely ill.

Chest X-ray was negative except for a mild pulmonary emphysema. X-ray of the bones did not disclose any evidence of metastasis. E. K. G. was normal. The upper gastro-intestinal tract was normal radiographically. The urine showed a trace of albumin and microscopically 100-150 w.b.c. The prostate on rectal examination was somewhat firm, non-nodular, fixed however.

On palpation of the abdomen the liver edge was palpable two fingers breadth. It was impossible to be sure about the mass in the right side.

Cystoscopic examination showed some protrusion of the prostate. The right ureteral orifice could not be made out. Finally a spurt of pus was noticed draining through a very small orifice on that side. An unsuccessful attempt was made to insert a catheter up the right ureter.

Percutaneous translumbar antegrade pyelogram was done on the right side after first withdrawing 50 cc. of purulent urine through a needle. The right kidney was found to be markedly hydronephrotic, and a nephrectomy was subsequently done. (Figure 2)

Case 3

Mr. J. R. P., aged 59, was admitted to the hospital due to hematuria December 3, 1953.

His previous history is significant in that a prostatectomy was done by us six months previous for acute re-



Figure 2

tention together with hematuria. His convalescence was very stormy; the N. P. N. and creatinine never became lower than 140 and 6.5 respectively. The present hematuria was quite profuse with no symptoms referable to the upper tract.

Cystoscopic examination was done December 5, and

a catheter was passed up the right ureter, but none could be passed up the left since there was an obstruction present in the lower ureter. However, spurts of blood were seen coming down through the left orifice. Bilateral retrograde pyeloureterograms were attempted, but the left kidney was not visualized. Only the lower portion of the ureter was seen, and it was found to be markedly dilated and tortuous.

The elevated N. P. N. and creatinine precluded intravenous urography.

On December 7 a trans-lumbar percutaneous antegrade pyelogram was done on the left side, and, after withdrawing 30 cc. of grossly bloody urine, 20 cc. of 15 per cent Diodrast was injected. We were unable to demonstrate radiographically the anatomy of the left kidney at this time; however, three days later the same procedure was attempted with fairly good visualization of the kidney. There was marked dilatation of the pelvis and calices with considerable thinning out of the renal parenchyma. The pelvis appeared mottled, suggestive of blood clots or a tumor. A uretero-pelvic junction obstruction was noted as well as some dilatation of the faintly visible upper ureter. (Figure 3)

Case 4

Mrs. L. B. S., aged 65, was admitted to Emory University Hospital March 21, 1954, with the following complaint: pain in the left side posteriorly in the lower left quadrant of the abdomen. She gave a past history of being worked out urologically in 1951 because of a bladder complaint and found to have an essentially normal upper urinary tract. However, pelvic examination disclosed carcinoma of the cervix for which she was treated. About a year ago her present symptom began and has become progressively worse. Due to rigidity we could not be sure about a mass in the left side, but it was thought she might have one.

Cystoscopic examination was made, and it was im-



Figure 3

possible to pass a catheter up the left ureter. A second attempt was made using a Braasch bulb in the lower left ureter and 10 cc. of Skiodan were instilled. X-ray showed some dye passing up the left ureter for a distance of three cm. No dye could be seen above this point.

Intravenous urograms were attempted and failed to demonstrate a functioning left upper tract. The right kidney appeared normal.

A translumbar percutaneous antegrade pyelogram was made and 20 cc. of dark colored fluid withdrawn; 15 cc. of Skiodan was then injected and a radiogram made which disclosed marked hydronephrosis of the left kidney apparently due to an obstruction in the left ureter. (Figure 4)

Case 5

Mr. F. H., aged 83, was admitted to the hospital February 15, 1955, for treatment of stomach ulcer. On March 9, while there, he developed a mass in the left side just under the left costal margin. It could be palpated from both front and back and was not tender. Temperature was normal. A plain roentgenogram disclosed a shadow in the region of the left kidney. There were quite a number of pus cells in the urine. (The prostate gland was resected three months earlier.)

Cystoscopic examination was done, and an impassable obstruction was encountered eight cm. up the left ureter. Retrograde pyelograms revealed only the distal ureter.

No dye was excreted by the left kidney on intravenous urogram.

A percutaneous antegrade pyelogram was done on the left side, after first withdrawing 60 cc. of turbid urine, which disclosed considerable hydronephrosis for which a nephrostomy was done. (Figure 5)

Case 6

Mrs. J. C. R., aged 56, was admitted to the hospital

October 29, 1954, with chief complaint of passing pus and blood in the urine.

She is known to have had a severe hypertension over a long time and to have passed small stones from the right kidney over a period from four to five years.

She was obese. Blood pressure was 210/110. The urine contained a few red blood cells and a few pus cells at this time.

Cystoscopic examination was done and a catheter passed up the left ureter without difficulty, but an attempt made to pass a catheter up the right ureter was unsuccessful, an obstruction being met just within the the orifice. A Braasch bulb catheter was inserted within the orifice and an attempt made to inject Skiodan and obtain a picture of the right kidney was unsuccessful.

A percutaneous antegrade pyelogram was done on the right kidney which disclosed a pyonephrotic sac containing multiple calculi for which a nephrectomy was done. (Figure 6)

Summary

In summary, we have presented our experience with translumbar percutaneous antegrade pyelography as an adjunct to urologic diagnosis. We have endeavored to describe the technique of this procedure, the indications, and show some of the results we have had. We have presented six cases wherein this procedure has been a definite help to us in diagnosis of urologic disease, and it is our impression after limited use of this procedure combined with other reports in the literature, that percutaneous antegrade pyelography is a valuable adjunct in the hands of the urologist in the diagnosis of pathological conditions which have defied clear pre-operative diagnosis.

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Figure 4

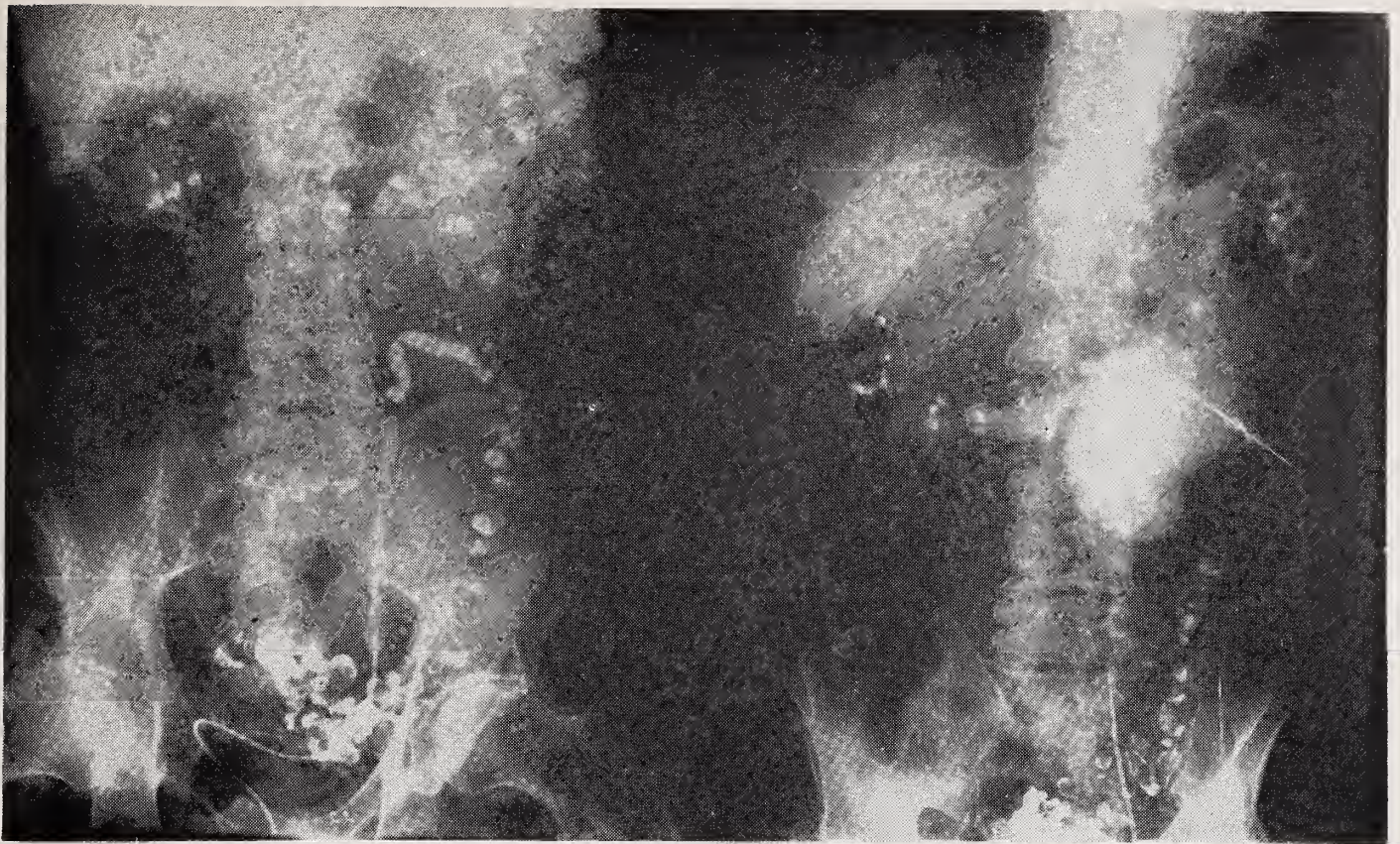


Figure 5



Figure 6

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Anesthesia in Office Practice

STUART C. CULLEN, M.D., Iowa City, Iowa

THE PHYSICIAN is often confronted with a patient in his office who needs anesthesia in order that effective therapy be accomplished. The disorders for which therapy is required include such things as lacerations, small abscesses, fractures, and ingrown toenails. The patients with these various ailments come to the office or the outpatient clinic with full stomachs, apprehension, and undiagnosed major disorders such as diabetes mellitus, coronary insufficiency, and active tuberculosis. As a class these patients constitute the most unsatisfactory anesthetic risk known. Most anesthesiologists would prefer to anesthetize a severe cardiac for a mitral valvulotomy or the repair of an atrial septal defect or a patient with advanced pulmonary disease for a pneumonectomy than a robust laborer, who comes with a full stomach, for the closed reduction of a dislocated shoulder. The opportunity for significant morbidity or for a mortality is about equal in all instances.

Nevertheless, these patients do need treatment, and in those circumstances in which appropriate therapy cannot be accomplished without anesthesia, it is necessary to develop a solution to the problem. There are fundamental principles which if applied to the problem will result in diminished hazard to the patient and better conditions for the physician. These principles include, (1) an evaluation of the patient, (2) preparation of the patient, (3) availability of proper equipment, (4) selection of agent and technique, and (5) personnel experienced in the administration of the anesthetic.

Evaluation of Patient

Each patient to whom anesthesia is to be administered (including local anesthesia) must have enough of a history taken and physical examination to make possible a reasonable estimate of the patient's state of health. Obviously, the situation does not permit an extensive examination and the performance of a number of critical laboratory tests. However, it is possible to elicit by appropriate questioning the state of the patient's respiratory and circulatory compensation. Simple inquiry into the patient's exercise tolerance, the presence or absence of dependent edema, and the presence or absence of orthopnea is often revealing. The physical examination should include not only a brief survey of lungs and heart,

but, more important a survey of the patient's habitus, the character of his airway, the presence or absence of dentures (and chewing tobacco or gum), and the degree of apprehension. The history should include inquiry into previous anesthetic experiences and tolerance to depressant drugs. Organic disorders which the patient may have will influence the anesthetic to be used, but probably no more so than the patient's build, the nature of his upper airway, and his apprehension. For example, the anesthesiologist confronted with two patients with ingrown toenails, one of whom is a robust athlete and the other of whom is a frail old lady, will certainly apply anesthetic drugs and techniques to each of these patients in a different manner. Time is well spent in an evaluation of patients, even in emergency procedures.

Preparation of Patient

Under the duress of emergency circumstances or a busy office, patients are often precipitated into anesthesia without even the slightest understanding of the process. This is especially true of children, and terrifying experiences with anesthesia often leave a significant psychologic impact upon children which influences their subsequent behavior in an unfavorable manner. It is especially important to take the time necessary to acquaint the patient with the anesthetic procedure to be employed. By so doing, one can appreciably improve the patient's response to anesthesia and diminish the hazard. It is amazing, and at the same time refreshing, to see how cooperative all patients, especially children, will become after the procedure has been fully and honestly explained. There is no advantage to be gained and considerable harm achieved by hoodwinking children into an anesthetic. They are smarter than you think, and the frustration associated with being tricked into such an experience is long lasting and finds expression in many undesirable actions.

In addition to the above preparation of the patient, it is often wise to take the time necessary to administer premedication. In office procedures this usually needs to consist only of the intravenous administration of a drug such as atropine or scopolamine. In some circumstances it is advisable to add a narcotic or a barbiturate. These medications are preferably given intravenously in order to insure full action of the drugs prior to the beginning of anesthesia. The drugs used for premedication and the amounts used will be dependent upon the physical

Presented at the 105th Annual Session of the Medical Association of Georgia, May 3, 1955, Augusta, Ga.

state of the patient, the anesthetic to be used, and the type and anticipated length of the operative procedure. It should be remembered that drugs given preanesthetically are poor substitutes for proper psychologic rapport with the patient.

One of the common hazards of anesthesia in these circumstances is the patient with a full stomach. As a general rule, one can be reasonably free of concern over this problem if the patient has not drunk or eaten within four hours. If there is reason to believe that the stomach is not empty and general anesthesia is needed, it is imperative that the stomach be emptied. (General anesthesia includes the production of a state of non-responsiveness by any route including rectal, intravenous as well as inhalation.) This can be done satisfactorily only by active emesis. It is not enough to insert a small bore catheter in the stomach because this does not remove food particles unless emesis is induced by the catheter. Emesis should be induced by gagging. In small children it may be necessary to induce very light anesthesia and evoke gagging before the pharyngeal and laryngeal reflexes are lost. It is well to be aware that many parents, although clearly instructed to bring a child in without food, will often be overcome by the child's pleas and fortify him for the coming ordeal by a chocolate bar or a glass of milk.

Obviously, the patient's clothing should be reduced to a minimum. Inspection should be made for dentures, chewing gum, and tobacco.

Equipment

Physicians who engage an anesthetist for anesthesia for patients in the office are often amused and amazed at the gear with which the anesthetist surrounds himself and the patient. Be assured that the equipment is there for the protection of the patient, and not to justify the fee to be charged. More than likely the anesthetist has had an experience which he would not care to repeat which was the result of having inadequate or non-functioning equipment.

In addition to the equipment necessary for the actual administration of anesthetic, it is necessary to have available a suction apparatus in good working order. Especially in emergency procedures, an aspirating appliance is mandatory. There is no more important piece of equipment.

In circumstances in which general anesthesia is not used, it is mandatory that some means be available for administration of oxygen. This equipment should be incorporated with a device facilitating artificial ventilation. Such equipment need not be elaborate or expensive—the ordinary anesthetic face mask and re-breathing bag is a simple, effective, and inexpensive device for resuscitation.

If local anesthetic agents are to be used, it is important to have available a soluble barbiturate and

a vasopressor drug for the treatment of reactions to these drugs.

It is useful, although not mandatory, to have endotracheal equipment available to facilitate ventilation if necessary. A sterile kit containing the tools necessary for tracheotomy is a useful and often life-saving unit.

It may have been noticed that no mention has been made of the traditional bag or box of stimulant drugs. It can be substantiated that the use of oxygen, ventilation, anticonvulsants, and vasoconstrictors are more effective therapeutic measures than the usual analeptics such as coramine, metrazol, alpha lobeline, caffeine, and adrenalin. There is no hesitancy in categorically denying that these drugs have any useful place in the physician's office, with the exception of adrenalin. Use of adrenalin should be limited to special circumstances such as the treatment of allergic responses, and be avoided as a panacea in hypotensive states, cardiac arrests, etc.

Selection of Agent and Technic

A suitable agent and technic can be selected by consideration of three questions: (1) What is the safest agent and technic for this patient for this operation under these circumstances? (2) What are the surgical requirements? (3) What will be most comfortable for the patient? It is impractical to list all the agents and technics available and match them with the patients and operative procedures so that one need only go to a table and pick the combination most likely to succeed.

There can be no satisfactory substitute for a working knowledge of the pharmacologic properties of the drugs available and a working knowledge of the physiologic effects of the various technics. If this information be known to the anesthetist, it is possible, with a knowledge of the patient's physical state and a knowledge of the operative requirements, to select a safe and satisfactory solution to the anesthetic problem.

Earlier it was pointed out that an evaluation of the patient is important. This enters into the selection of the drug and method in the following manner. For example, if the patient has coronary insufficiency, it will be wise to avoid an anesthetic such as pentothal that will provoke significant hypotension. If the patient has hypertension, it will be wise to avoid the use of high concentrations of a vasoconstrictor in local anesthetic solutions. If the patient is a robust bull-necked individual, it will be wise to avoid relaxation which will precipitate difficulty in maintaining an adequate airway. If the patient is very apprehensive, consideration should be given to avoiding local anesthetics. If the patient has a full stomach, general anesthesia should be avoided, if possible, unless the stomach is emptied.

The surgical requirements should also be clearly defined. For example, is relaxation necessary and to what degree, how long a procedure will it be, and will there be a fire or explosion hazard from the use of cautery?

A pattern of selection by elimination may be applied conveniently to the solution of anesthetic problems in the office. One may approach the selection of agent and technic by the following method.

It may be assumed that the safest anesthetic to be employed in the office is local or regional anesthesia. As a consequence, one may ask himself if the patient is suitable and the operative procedure can be accomplished satisfactorily with local or regional anesthesia. For this type of anesthesia there are innumerable drugs available. In general, one would employ that drug which will give adequate anesthesia with the lowest concentration and the lowest total amount. It should be remembered that unfavorable responses to these drugs are in direct proportion to the concentration used and the amount applied. The physician should become familiar with a number of simple yet useful blocks and not confine himself to infiltration anesthesia alone. Nerve blocks for anesthetic purposes are often usable in circumstances in which infiltration is inadvisable or impossible.

If infiltration or regional anesthesia is deemed not suitable, analgesia by inhalation may be considered. With this technic it is possible to provide pain relief and still retain the patient's cooperation and his protective reflexes. There are several agents which facilitate this type of anesthesia. Vinethene and trichlorethylene are especially adaptable to analgesic technics. They may be used by the open drop method or in combination with nitrous oxide. The development of the analgesic state is contingent upon close attention to the patient and constant adjustment of the concentration to the patient's responses. The use of self administered analgesia such as with the trilene inhaler is useful in a few circumstances, but since the patient cannot successfully interpret his own responses, the administration of a fixed concentration will fail to provide satisfactory analgesia in many cases. In addition, there is a real hazard associated with the use of such devices in that the patient will not always relax with the production of the analgesic state. They may become rigid and hold the mask on tighter with the consequent development of deeper anesthesia, higher concentrations, relaxation, airway obstruction, and ultimately cardiac irregularities. In addition, the patient with a full stomach may vomit in a state in which protective reflexes are obtunded. Furthermore, trilene is a potent agent capable of evoking significant cardiac irregularities similar to those of chloroform. As a matter of fact, chloroform

is an excellent agent for analgesia and could be substituted for trichlorethylene without increasing the hazard.

Another simple approach to anesthesia for office practice is the judicious use of narcotics intravenously. For procedures such as cystoscopy, myringotomy, etc., in which no significant relaxation is needed, short acting but potent narcotics such as Nisentil may be administered intravenously with excellent effect. The addition of narcotics intravenously is also a useful aid to local or regional anesthesia.

The induction of general anesthesia, whether it be by inhalation or intravenous route, may be accomplished by any of the agents available. One usually avoids those with fire and explosion hazard such as cyclopropane, ether, vinethene, and ethylene. In addition, one usually prefers to employ an agent with which quick induction and recovery can be effected. In this respect, it must be remembered that although induction is rapid with an intravenous agent such as pentothal, the recovery may be prolonged. It must also be remembered that by introducing an agent such as pentothal intravenously, one does not avoid the problems associated with relaxation of the jaw and obstruction of the airway. As a matter of fact, this agent usually enhances the problems of airway management.

Personnel

The success of anesthesia in any circumstance, and especially in the less favorable circumstances of office practice, is dependent largely upon the anesthetist. The person using the various drugs and methods must familiarize him or herself with them. This does not imply that anesthesia must be done only by trained and experienced anesthetists. There is no doubt but that the results will be more satisfactory with experienced personnel, and one must accept the risk associated with anesthesia done by less well trained anesthetists. However, if one is willing to take a calculated risk, the physician in office practice can learn to apply useful and acceptable solutions to the anesthetic problems encountered in the office.

The important factor in safe anesthesia in these circumstances is the adoption of an attitude that anesthesia is a state in which there is little margin of safety. The drugs employed are highly toxic and exert their effects only with concentrations and doses which are not far removed from poisonous levels. This awareness of trouble is important in determining the care with which anesthesia is practiced. It is apparent that many patients have successfully survived anesthesia under the unfavorable circumstances of office practice. It is also apparent that many patients have survived the effects of misdirected therapy in the office. It is, on the other hand, apparent that

(Continued on next page)

History Notes

THE FIRST WOMAN DOCTOR in Georgia was Palatia Harrison Wilson Stewart, better known as Dr. Polly Stewart. She was the daughter of Larkin and Mary Cabiness Wilson and was born April 2, 1805, on a Jones County plantation two miles east of what is now Bradley. (Her home has recently been restored by its present owner, Mrs. Doris Hungerford Fraley.) Her grandparents, George and Palatia Harrison Cabiness, lived a mile or two away at what was later known as the Glawson Place; the house was torn down only a few years ago. In front of this home were the drill grounds of the County Militia. The men who drilled there in the 1840's and 1850's fought in the War Between the States, and most of them never came back.

Polly Wilson a striking brunette who at 16, married Thomas Ware Stewart, a fine man twice her age, of sturdy Presbyterian stock. He took his bride to his small plantation near old Fortville. They had 13 children, and through their efforts added to their farm until they had a plantation of 2,000 acres of land and about 100 slaves. Her husband died when their thirteenth child was six weeks old. With all that Polly had to do, she studied for and passed the examination and was awarded a diploma in medicine by "The Botanico Medical Society" of Hartford, Connecticut. Miss May Stewart, her granddaughter, has this diploma now.

She strongly believed in education, and saw to it that her children had every opportunity to become educated.

Her service as a doctor to the counties of Jones, Jasper, and Baldwin was an heroic effort during the

War, and she had six sons in the Confederate Army. One, Polk Stewart, was killed at Savannah. No man in Jones County did more than did Polly Stewart. During these terrible days, without a son to help, she kept her plantation producing food for the soldiers, and she had the wool spun, woven, and dyed into the beautiful confederate gray and made into clothes for Confederate soldiers. She organized and became president of the Jones County Soldiers' Relief Society. Later, Captain Richard W. Bonner declared that the Confederacy should erect a monument in her memory for her devoted services during the War.

She nursed and cared for the Federal soldiers wounded at Sunshine Church in August and September of 1864, driving seven miles each day to bring medical aid and food. The Federal officer in charge gave her signs to post on her plantation asking that no Yankee destroy her property. When Sherman's forces came through Jones County in November 1864, his regular troops respected the signs but the bummers and stragglers did not.

She died on July 11, 1866 at the age of 61. There are many descendants of this outstanding woman living in the South now. Dr. Stewart's youngest known namesake is her great great great granddaughter, Helen Palatia Hunt, year-old daughter of Jasper Stewart Hunt, M.D., of Charlotte, N. C., formerly of Powder Springs.

(A full account of Dr. Stewart's life is in the *Jones County History*. This summary was written principally from an article in the *Jones County News*, October 21, 1955. Ed.)

Anesthesia in Office Practice (cont.)

too many patients have not survived anesthesia administered in the office, and this realization should be a sobering factor.

Summary

One often hears the statement that many anesthetics have been administered without any trouble. In evaluating such statements, one must inquire into the definition of trouble—is survival the sole determinant of lack of trouble? In addition, one must inquire into the number of patients involved—over a period of several years, the number of patients successfully surviving anesthesia in the office may amount to only 5,000. One serious morbidity or

mortality in 5,000 patients, even if it takes 15 years of practice to reach this point, is a high death rate.

It is exasperating to take the time necessary to evaluate a patient for anesthesia, to prepare him properly, to select an agent and technic on an individual basis and to be careful in the administration of the anesthetic. On the other hand, it is even more exasperating and embarrassing to attempt to explain to friends, relatives, and colleagues why a healthy patient who walked into the office had to be carried out in a basket.

*University Hospitals
State University of Iowa*

Polio Ahead:

The Reason Behind the 1956 Georgia March of Dimes

HART E. VAN RIPER, M.D., New York, N. Y.

SINCE THE GEORGIA Warm Springs Foundation, incorporated in 1927, was the forerunner of the National Foundation for Infantile Paralysis, organized in 1938, physicians in Georgia have had a longer experience than those in other states with organized efforts to combat paralytic poliomyelitis and its damaging after-effects. Nevertheless Georgia will still have its polio problems in 1956.

The Salk vaccine has proved to be a major weapon against paralytic poliomyelitis, but it has not yet won the war against this disease.

Continuing cooperation of physicians must be had both in administering the vaccine and in caring for patients already paralyzed and *who will be* paralyzed in spite of the vaccine. The Salk vaccine is not 100 per cent effective, and it will take considerable time, perhaps years, before all individuals most susceptible to paralytic poliomyelitis can be fully immunized against it.

The National Foundation for Infantile Paralysis, supported through public contributions to its January March of Dimes, has made an enviable record, both in this state and nationwide, for meeting the problems posed by paralytic polio. In 1955 the March of Dimes gave nearly 368,000 cc. of Salk vaccine without charge to the State of Georgia to initiate a statewide vaccination program. In addition 15,000 cc. of gamma globulin were supplied.

The results already reported from the use of the vaccine are most encouraging but they must not be allowed to blind the eye of the medical profession to the road that still lies ahead. There remains a great need for additional research to improve the Salk vaccine, to determine the duration of immunity it effects (and conversely to determine the need for "booster shots"), and to provide the best possible treatment for patients already or yet to be involved with paralytic poliomyelitis. There is also a vast need for the

professional education of young men and women who will contribute to the necessary research and help give the needed treatment.

To pay for research, education and aid to polio patients, the March of Dimes needs \$47,600,000 in 1956. Georgia physicians, knowing both the need and the record, will want to support and urge their patients to support the 1956 March of Dimes in their own communities.

A brief review of the record of the National Foundation for Infantile Paralysis in Georgia, where it has 152 local chapters, should help to orient physicians to the many services to patients and the professions which have been made possible by the March of Dimes since 1938.

Over \$3,710,000 has been spent by local chapters in Georgia for the care of polio patients.

In addition to its grants of over \$5,000,000 to the Georgia Warm Springs Foundation, the March of Dimes has made grants totaling over \$231,000 to Emory University for virus research, for research in the after-effects of poliomyelitis, and for professional education. A grant to the Medical College of Georgia is in process.

A total of 73 National Foundation scholarships and fellowships has been awarded to Georgia residents.

Emergency aid in dollars and in equipment for polio patients has been generously supplied to Georgia. In the first 10 months of 1955, for example, a total of \$118,000 in emergency aid was sent to 33 Georgia chapters by the national headquarters of the National Foundation. In the year 1954 the amount was over \$174,000 to 63 chapters.

A total of six tank respirators, five chest respirators, and seven rocking beds was sent into Georgia as emergency shipments in the first 10 months of 1955. In the previous year Georgia got 19 respirators and one rocking bed.

The author is Medical Director of the National Foundation for Infantile Paralysis.



The Effectiveness of Georgia's Medical Examiners

PRIOR TO MAY 10, 1953, many people over the state were seriously perturbed about laws regarding inquiry into deaths under suspicious circumstances. Among these was the Honorable B. C. Gardner, then Representative, Dougherty County, who made an intensive study over a two year period of the desirability of a combined coroner-medical examiner system. This resulted in passage of the Georgia Post Mortem Act during the 1953 Legislative session. The uppermost question on May 10 was whether or not this legislation, now placing the burden on the medical examiner and officer, would adequately and effectively resolve the somewhat haphazard inquiries into a more sound analysis based on scientific medico-legal investigation.

It is now possible to take a backward glance over the two and one half year period. The first step was the recruiting of at least one medical examiner per county. This duty was assigned by the Act to the Directors of the Crime Laboratory and Department of Public Health, under whose jurisdiction the Medical Examiner System was to function. Six months and thousands of miles later, about 100 members of the medical profession had graciously assumed their civic obligation by accepting appointments. At present this number has been swelled to 217. Many stated they did not feel qualified to perform a medico-legal autopsy; yet, appreciating the need of such a program, they were most willing to assist as far as possible and furthermore delve into the study of legal medicine.

The results have been amazing. Prior to passage of the Post Mortem Act there were from one to five disinterments per month. In the two and one half year period since passage of the Act there has been only one disinterment. This speaks for itself. If there were no other benefits this fact alone would prove the effectiveness of the legislation.

Under the old coroner system very few postmortem examinations were ever held. Currently, such examinations average 75 per month. Many homicides are solved and criminals apprehended because of the medicolegal post. Many convictions are obtained because an air-tight case can be presented showing the exact cause of death thus preventing the question of a "reasonable doubt" so necessary to the defense. One of the many outstanding examples is

a case in Hall County in which Hamil Murray participated as medical examiner.* His exacting work in tracing the paths of many shotgun pellets and a rifle bullet through the body with exact measurements of each wound, his full and accurate report—three legal size single spaced typewritten pages—and excellent testimony in the courtroom resulted in the conviction of two members of a family for the murder of a third in cold blood.

Perhaps even more valuable is the situation in which suspected foul play with its accompanying vicious rumors is often revealed to be an erroneous assumption, and the cloud of suspicion is removed from the innocent suspect.

In the courtroom the testimony of the medical examiner has been a welcome relief because of its exactness and specificity.

In the Department of Vital Statistics, according to its director, much more accurate information is available from death certificates for statistical purposes.

A sincere "thank you" to the medical examiners of the State of Georgia, whose tasks are exacting, demanding, and tedious but so vitally necessary to effective crime detection.

Acute Obstruction of the Small Intestine

CHANGES OCCURRING in the patient with intestinal obstruction have been well described. Despite this, the entity remains a treacherous one. In examination of a patient with acute abdominal distress where the presence of intestinal obstruction is entertained in differential diagnosis, the following practical features are significant:

1. Peristaltic sounds: The typical crescendo-like rise of peristaltic sound to a peak, and the subsequent tinkling noises, are frequently absent. This is particularly true in the very early stages. More noticeably, those patients with "textbook" peristaltic sounds of obstruction have presented themselves at the hospital in a late stage. In early acute obstruction, then, one may hear fast runs of peristalsis, which even to the practiced ear sound like those of very hyperactive motility. They are comparable to the type heard in young children immediately after a meal, or in those patients with gastroenteritis.

* See AMBUSH by Dr. Herman D. Jones, *The Georgia Peace Officer*, Sept.-Oct., 1955, p. 19.

2. Narcotics: A moderate sized single dose of Demerol or morphine may resolve all signs and symptoms of an early acute obstruction for as long as 12 to 24 hours, while the pathological change continues at a rapid pace. It is known that the symptoms of acute gastroenteritis simulate those of early obstruction. Because opiates have such a widespread use (and rightly so) in prompt relief of patients with gastroenteritis, the responsible physician must make a very keen effort to establish an accurate diagnosis before institution of therapy which includes narcotics.

3. Operations: Acute small intestinal obstruction is reported and occurs in a number of patients who have not been subjected to previous abdominal surgery. The absence of a well-healed abdominal scar, therefore, is no aid in the differential diagnosis. In all age groups, congenital defects, volvulus, adhesion bands, or internal hernia may be the etiological factor.

At the opposite end of the diagnostic spectrum are those patients who have been recently operated on. Adhesions can form and produce acute obstruction in less than five days. Therefore, abdominal pain in the immediate post-operative patient must be carefully evaluated.

4. Naso-gastric suction: The use of naso-gastric suction, with a Levin tube or long intestinal tube (Miller-Abbott, etc.) can obviate all signs and symptoms of intestinal obstruction. Simultaneously the encroachment on the blood supply of a segment of bowel progresses, and all too frequently gangrene results without the usual tell-tale signs.

5. X-ray changes: Radiologists readily admit that with the use of plain films in abdominal diagnosis, differential diagnosis of paralytic ileus and intestinal obstruction is frequently impossible. X-rays have also been obtained in completely obstructed patients that fail to demonstrate any air or fluid-filled loops of intestine.

More and more, radiologist and surgeon depend on the judicious use of various contrast media as diagnostic aids in equivocal cases.

6. The constant factor: Of all the observed changes which are recorded in descriptions of in-

testinal obstruction, the one outstanding and ever-present observation is that of *cramping, colicky pain*. If this symptom exists, the patient must be considered to have intestinal obstruction until proven, irrevocably, otherwise.

The Right to Be Ornery

A RECENT ISSUE of a weekly magazine of large general circulation carried an article by a doctor describing the tremendous increase in law-suits against the medical profession for mal-practice. Why should this be? As any grievance committee can testify, it is quite obvious that most of these law-suits have been generated by what may be described in one word as, "orneryness"—orneryness on the part of both the patient and the doctor.

The medical profession is not made up of a band of little tin angels, but we think there is no doubt that there has grown up among us a breed of mental neuters worshipping a sort of cult of neutrality. We are surrounded by socialization, social security, community chests, and near socialization of medicine, all of which force us into conformity to the group and to the times. While we are not in favor of maladjustment, we look with some misgivings upon this cultivation of neutrality and would welcome a few oddities and "characters" among the medical profession. We are all aware that it is a part of our American heritage to be free and independent. We have a right to be bewildering and idiosyncratic, and while we have the right to be ornery, just as we have the right to be free and independent, we also have with these rights a heavy responsibility to be ornery or idiosyncratic at the right time and in the right place.

So, take it easy doctor. Watch carefully your public display of rugged individualism. Some people may accept it for what it is, but others may decide you have no right to be different, and get ornery too—ornery enough to sue you in a court of law.

Remember the Irish immigrant who, upon arrival in this land of freedom, threw his fists about him in an exaggerated display of this new freedom. When he woke up, after being knocked down, he was much chagrined to hear some friendly advice from Mike O'Leary: "Patrick, niver forgit that your freedom ends where the other man's nose begins!"

Did You Know?

THE GRADY MEMORIAL HOSPITAL School of Medical Technology has been awarded a "superior" rating of 100 by the American Medical Association, it was recently announced by John Hinman, Assistant Di-

rector, Division of Hospitals and Graduate Education. This rating was given, following the annual evaluation of the Association's Council on Medical Education.

Pulmonary Edema

WILLIAM B. FACKLER, JR., M.D., LaGrange, Ga.

CLASSICAL ACUTE pulmonary edema presents a picture as unmistakable to the clinician as it is alarming to the patient. Onset with anxiety is followed by progressive dyspnea, orthopnea, and cough as interstitial edema develops. Moist rales become audible wheezes while alveoli are flooded by transudate. Whipped into froth by labored respiration, this fluid is coughed up first in tufts of pink meringue then in soupy gushes as it fills the major bronchi. Deepening cyanosis, fading consciousness, and shock herald imminent disaster for the drowning victim. Unless the choking tide is stemmed, anoxia chokes vitality into submission; the heart flags, respiration diminishes to shallow gasping, and the patient dies.

Perhaps such a description takes unwarranted liberty with scientific objectivity. Yet few medical emergencies present so dramatic a sequence of visible physiologic changes which imperil life; fewer still present so compelling a challenge to the clinician's skill.

It occurs in degree ranging from very mild to fatal. Although cardiac failure of one cause or another bears the brunt of blame, a wide variety of conditions may lead to pulmonary edema. The list includes hypertensive crisis, renal disease, pheochromocytoma, toxemia of pregnancy, cerebral disease, insulin shock therapy, thoracic deformity, lung disease (burns, contusion, drowning, pneumonia, pneumothorax, irritant gases), infusion of blood, plasma and saline, drug intoxications, allergic reactions, febrile disease, shock and surgical stress.

The cause of pulmonary edema is unknown. Experimental data indicate that the vasomotor and physiochemical events which are enacted in the neighborhood of the alveolar membrane are highly complex, the variables being: (1) capillary hydrostatic pressure, (2) oncotic pressure, (3) membrane permeability, and (4) pulmonary lymph drainage. Consistency with which capillary pressure is found to be elevated emphasizes the importance of this factor. It correlates well with the practical fact that increasing lung blood inflow and decreasing outflow aggravate pulmonary edema while decreasing inflow and increasing outflow ameliorate it.

Therapeutic measures may be grouped according to the influence they have on the above factors. Since

the effect of anoxia on the body's ability to recuperate can be disastrous, an open airway is mandatory. Tracheal suction (aided in the operating room by intubation) clears the major bronchi. Removal of a large quantity of fluid may be tantamount to phlebotomy. Ethyl alcohol vapor when inhaled in low concentration acts as an effective anti-foam agent. This permits oxygen exchange in the presence of much more alveola fluid than can usually be tolerated and operates independently of the pathology underlying the edema. Oxygen administration by tent is inefficient but has the advantage of a desirable cooling effect. Administration by more efficient means exposes emphysematous patients to the danger that relief of hypoxia may remove the only functioning respiratory stimulus. Intermittent positive-pressure breathing has merit and is well adapted to use in the operating room.

Several measures which reduce systemic venous return, and thus reduce pulmonary inflow, improve pulmonary edema but aggravate and may even precipitate shock. These include (1) the erect position, (2) tourniquets, and (3) phlebotomy, rapid removal of 500 cc. of blood being helpful when release of tourniquets results in reappearance of edema.

Emptying the pulmonary vascular bed is effected by agents such as aminophyllin, sympathetic blocking agents, and spinal anesthetics. They seem to accomplish this through peripheral vasodilatation, which is an area wherein future improvements may well take place.

Other agents deserve comment. Morphine, which is of great value in calming patients, may cause distressing vomiting and dangerous respiratory depression. Atropine appears to exert favorable influence on the reflexes operative in pulmonary edema and is seldom contraindicated. Digitalis is of benefit chiefly to patients in a general state of decompensation. Mercurial diuretics operate too slowly to be effective in an emergency. The edema which occurs in hypertensive crisis usually responds to drugs such as proteratriner (0.1 mg. I.V. in three minutes followed by 0.02 mg. I.V. every 10 minutes) which lower the pressure. Pulmonary edema complicating shock of myocardial infarction, though of poor prognosis, often is affected favorably when the shock responds to plasma and pressor substances.

Prepared at the request of the Committee on Professional Education of the Ga. Heart Assn.

abstracts by georgia authors



LaVeck, Gerald D., John F. Winn, DVM, MPH, and Sarah F. Welch, Communicable Disease Center, Public Health Service, U. S. Dept. of Public Health, Atlanta, Ga. "Inapparent Infection with Western Equine Encephalitis Virus: Epidemiologic," AM. J. PUB. HEALTH 45:1409-1416 (November) 1955.

Sera obtained from 614 inhabitants of Weld County, Colorado, during 1954 were tested for neutralizing antibodies against WEE to determine the frequency and epidemiologic pattern of inapparent infections. Antibodies were demonstrable in 10.9 per cent of the sampled population. For persons under 30 years of age the rate of positive sera was twice as high as that for persons over age 30. Although males and females had similar rates when all ages were considered, the percentage of positives was greater in males than females in the age group 15 to 30 years, but was higher in females over age 45. Residents who had lived in the county for the past 15 to 24 years had higher rates than other residents. No significant difference was noted in the frequency of inapparent infections in rural and urban areas nor in irrigated and non-irrigated land. A higher per cent of persons with outdoor employment had positive sera than those with indoor employment. Farmers and manual laborers led other occupational groups in percentage of positive reactions.

Seventy-eight individuals were bled in the spring of 1954 and again in the fall to determine the incidence of inapparent WEE infections during the summer months. None converted from negative to positive.

Equen, Murdock; George Roach, Robert Brown, and Truett Bennett, 144 Ponce de Leon Ave., N.E., Atlanta 8, Ga. "Open Safety Pin in the Esophagus of a Septuagenarian," ARCH. OTOLARYNG. 62:426-427 (October) 1955.

In the cool early morning hours of September 26, 1954, an old lady had to get out of bed. While adjusting a shawl around her shoulders she put an open safety pin in her mouth. In some way she swallowed it.

An x-ray made by her physician, Bernard P. Wolff, showed the pin in the mid portion of the esophagus, its point up. An Equen magnet mounted on a ureteral catheter was introduced into the esophagus under fluoroscopic guidance, and with the magnet the pin was led by its ring into the inflated stomach. There it was reversed and then drawn back up the esophagus, its point harmlessly trailing. The pin was stripped from the magnet at the cardiac end of the esophagus on account of achalasia or perhaps stricture, but was promptly retrieved by the use of the esophagoscope and forceps.

We have seen many cases of open safety pins swallowed by small children. The last 10 years we have removed them with a magnet as described above; we are con-

vinced that this is the simplest and safest way to get them. It is unusual for an older person to ingest a safety pin, and when it occurs, the patient may be expected to wear dentures.

Kite, J. Hiram, 490 Peachtree St., N.E., Atlanta, Ga. "Arthrogryposis Multiplex Congenita: Review of Fifty-four Cases," SOU. MED. J. 48:1141-1146 (Nov.) 1955.

Congenital limitation of motion in several joints, accompanied by one or more congenital deformities is a rare condition which presents a fairly typical syndrome. While many names have been given to this condition it is best known to Americans as arthrogryposis multiplex congenita. It is being reviewed at this time because of the sudden increase of this condition in my practice during this past year, and because 54 cases treated personally are available for study. A review has been made of the literature, nomenclature, and etiology. As to heredity, the genetic theory is substantiated by the fact that three arthrogryptic parents have had children with similar deformities. It is disproved by the fact that there were three sets of twins, one in each set normal and one arthrogryptic. In one set the twins were identical. The arthrogryptic was the first child born in one-third of the cases. Only half of the babies were full term. A third weighed less than seven pounds. Arthrogryposis occurs more frequently in charity patients than in private practice. A tabulation has been made of the joints involved.

There were 63 per cent boys and 37 per cent girls, which is the same ratio as in congenital clubfeet. Seventy per cent of the patients were clubfooted. Fourteen per cent had severe flatfoot deformity, and ten per cent had metatarsus varus like deformities, and only four per cent had no foot deformities. Forty-three per cent showed congenital dislocation of the hips. The dislocation of the hips in arthrogryptics is usually of the prenatal type. There is a very deep false acetabulum at birth. The cases in which no attempt at reduction was made seemed to have better hips than those which were reduced. The treatment consisted in correcting the foot deformity with casts. Occasionally, an osteotomy was needed for the joints with fixed flexion deformity. A few required braces.

Burnet, C. P., G. P. LaVeck, and J. F. Winn, CDC, P.O. Box 135, Chamblee, Ga. "Absence of Neutralizing Antibodies Against Western Equine Encephalitis in Sera of Children With Epilepsy," J. OF IMMUNOLOGY, 75:330-331, 1955.

This investigation failed to demonstrate an association between idiopathic epilepsy and inapparent WEE infection. Only one of twenty-eight epileptic patients had antibodies against WEE, compared to a control group of 89 children of which five had antibodies against WEE.

Ray, Charles D.: Medical College of Georgia, Augusta, Ga. "Configuration and Lateral Closure of the Superior Orbital Fissure,"

AM. J. PHYS. ANTHROPOL. 13:309-321 (June) 1955.

A study of 530 male and female, white and Negro crania, classifying the configuration of the superior orbital fissure and the bony participation in the lateral closure of the fissure. Results in tabular form demonstrate interrelations of the variations and the degree of similarity between fissures of each cranium in the race and sex groups. Drawings and photographs illustrate criteria for scoring these variations. The most divergence between any groups is found between Negro males and white females. Fifteen anthropoid specimens are included in discussion. Widening and blunting of the fissure is suggested to be a phylogenetically early type.

Kelly, G. Lombard, Medical College of Georgia, Augusta, Ga. "Problems of Impotence in Aging Males" J. AM. GERIAT. SOC. 3:883-889 (Nov.) 1955.

The principal problems of impotence in aging males are stated, followed by a discussion of the incidence and types. Especial emphasis is laid on the great preponderance of psychogenic over organic impotence. The influence of the sympathetic and parasympathetic nervous systems is discussed in an account of the physiology of erection. Under treatment the need for a careful physical examination is stressed. In addition to the use of essential nutritive substances, especially liver extract and B vitamins, treatment is discussed under the headings of education, drugs (stimulants and sedatives, androgens, local anesthetics, local stimulants) and mechanotherapy. Androgens and possibly recently available FSH preparations are suggested if sterility should be a problem. The author believes that research in this field is greatly neglected.

McClure, James H., and William L. Caton, 69 Butler St., S.E., Atlanta, Ga. "Newborn Temperatures, I: Temperatures of Term Normal Infants," J. PEDIAT. 47:583-587 (November) 1955.

During a period covering 7,379 deliveries at the Ohio State University Hospital there were found 20 patients with typical grandmal attacks and without demonstrable organic pathology. It was noted early in the study that this group of patients was generally uncooperative, and their voluntary discontinuation of medication was comparable to that of the notoriously uncooperative "young" diabetic. Nineteen of the patients were clinical cases and one was a private patient; yet the overall rates of clinical to private cases in this hospital was three to two. All patients were followed by a neurological consultant and all were under active treatment.

One patient developed status epilepticus at eight months gestation and was controlled only after cesarean section. A clinically parallel case (not included in the series) developed status epilepticus at 7½ months gestation and too was controlled only by cesarean section. This lat-

ter patient had oxycephaly with internal hydrocephalus.

As far as could be determined, idiopathic grand-mal epilepsy is without effect on pregnancy except for the patient with status epilepticus; the effects of pregnancy on idiopathic epilepsy are unpredictable. In this series the majority of patients had more frequent attacks with pregnancy.

Thirty-five references; three tables.

Cleckley, Hervey M., and Corbett H. Thigpen, Medical College of Georgia, Augusta, Ga. "The Dynamics of Illusion." AM. J. PSYCHIAT. 112:334-342 (November) 1955.

The enthusiastic chant of *dynamics, the dynamics, the psychodynamics* seems to make a music that can dominate discussion and sometimes deafen ears to the fact that voluble commentators are not necessarily talking sense. Dynamic, "a word that deserves to be paid overtime," is sometimes used plausibly by able psychiatrists and too often also by glib theorists to confer the status of science upon almost any assumption about the unknown. It is the custom of our day for psychiatrists to use the vague jargon of psychodynamics much as an unsuperstitious German politely says "Gesundheit," when his companion sneezes. By some the terms are manipulated to provide easy explanations for many things which cannot be proven and to manufacture specious evidence for implausible theories through altering definitions to fit the assumption. Our psychiatric journals today continue to present methods and conclusions in the name of science that are not less visionary than those of phrenology which a century ago similarly misled many of the best minds in medicine. This, as Freud demonstrated memorably in *From the History of an Infantile Neurosis*, provides a method so elastic that it can readily be used to arrive at almost any conclusion that comes to mind. Do not such methods serve ideally to create a dynamics of illusion?

Abbott, Osler A.; William Van Fleit; Albert E. Roberto; and Frank P. Salomone, Emory Hospital, Emory University, Ga. "Studies of the Function of the Human Vagus Nerve in Various Types of Intrathoracic Disease." J. THORACIC SURG. 30:564-590 (Nov.) 1955.

This paper is concerned with a study of the role of the autonomic nervous system in relation to various types of pulmonary pathology. A review of the knowledge at present existent concerning the dynamics of pulmonary flow in different types of pulmonary disease is reviewed. The purpose of the study is to increase our basic knowledge relative to the physiologic and pathophysiologic function of the human vagus nerve in relation to pulmonary dynamics. The study presents a series of patients with different types of intrathoracic disease in whom cardiac catheterization was performed. In this group the effect of the administration of vagus nerve blocking agents upon the pressure in the right ventricle, in the pulmonary artery at rest and after exercise, are recorded. In the second group of patients the studies were performed at the time of thoracotomy. Direct pressure tracings were obtained from both the pulmonary artery and the pulmonary vein of the exposed lung, noting the effect of different levels of intrabronchial ventilatory pressure upon pulmonary dynamics before and after direct novocaine blockage of the vagus nerve.

The studies reveal a specific pattern of behavior of the pulmonary dynamics in different types of intrathoracic disease. A very specific pattern is noted to occur in patients with pulmonary emphysema and further emphasizes the role of vagus nerve in this disease. The danger of high intrabronchial ventilatory pressure appears to be much more marked in patients having either mitral stenosis or pulmonary emphysema. The studies allow one to define the presence or absence of secondary changes in the vascular bed of the lung. Furthermore, the studies allow one to define specifically the stage of pulmonary emphysema present and indicate the type of denervation procedure indicated for each individual case. This study opens up a new approach to the study of intrathoracic disease and many new interesting investigative problems are suggested.

Chambers, William R., 478 Peachtree St., N.E., Atlanta 8, Ga. "Neurosurgical Conditions Masquerading as Psychiatric Diseases," AM. J. PSYCHIAT. 112:387-389 (November) 1955.

The diagnosis of intracranial tumors may be missed due to psychiatric or psychosomatic manifestations. Of one hundred brain tumors, taken consecutively, at one clinic, 32, or approximately one-third, were originally diagnosed as an emotional disorder or "nothing wrong." In a large series of autopsies at one mental hospital, brain tumors were shown to be present in 3.45 per cent, and in another hospital as high as 13.5 per cent. Meningiomas accounted for from 20 to 30 per cent of these.

The most common locations of tumors simulating psychiatric conditions were in the frontal or temporal lobes, and the most common tumor of all is a meningioma of the olfactory groove. Because of their location and nature, these tumors frequently are not associated with papilledema. Typical of the seven cases presented was that of a 47 year old school teacher who had lost a favorite brother because of brain tumor. About 10 years after his death she witnessed a convulsion in one of her pupils, and thereafter she began to have headaches and nausea whenever she was under emotional stress. The only element of history of importance was that six years previous she had suddenly lost her vision in the left eye and had remained blind on that side since. Examination by an ophthalmologist failed to reveal the cause. She continued to vomit more frequently even up to four or five times a day, but was permitted to persist in her teaching until she became too drowsy to stay awake in her classroom and could hardly read. She died suddenly of meningioma of the tuberculum sella.

It is obvious from the literature and from these cases that patients may be saddled with a diagnosis of mental disease when a curable tumor is really the cause of their symptoms. Hallucinations, personality changes, narcolepsy, psychoneurosis, and neurasthenia should be more critically scrutinized, particularly when associated with headache. Commitment to psychiatric institutions should be done only after examination of the patient by neuro-psychiatrist, a neurosurgeon or both.

Torpin, Richard, Medical College of Georgia, Augusta, Ga. "Excision of the Cul-de-Sac of Douglas," J. INTERNAT. COLL. SURGEONS 24:322-330 (Sept.) 1955.

The author presents his method of vagi-

nal repair of enterocele as an integral part of the usual standard operations for cystocele, urethrocele, and rectocele.

A brief discussion of the supportive tissue is given as rationale for this procedure which consists of a wedge excision of the herniated cul-de-sac, including the excessive peritoneum, fascia, and mucosa, and closure by means of a double strand of catgut suture.

This is the second report on the procedure, which since 1938 has been used on all cases of enterocele *per se* and on all cases which at the time of vaginal hysterectomy and repairs presented a bulging cul-de-sac which could be depressed by a finger in the peritoneal sac down to the level of the introitus. The first report in 1946 covered 44 patients, and this report adds an additional 135. In this series there were no known recurrences and it is pointed out that in no patient was there a vaginal depth of less than eight cm. postoperatively.

The operation is readily adapted to those in which it is desirable to preserve the uterus by usual initial transverse post-colpotomy incision.

The technique of the method is illustrated with six diagrams.

Klayman, M. L., B. W. Massey, S. Pleticka, J. T. Galambos, L. Brandborg, J. B. Kirsner, and W. L. Palmer, Emory University, Ga. "The Cytologic Diagnosis of Gastric Cancer by Chymotrypsin Lavage II," GASTRO-ENTEROLOGY 29:854 (Nov.) 1955.

Three cases are reported illustrating the contribution of exfoliative cytology in the detection of early gastric cancer. The problem of recognition of a microscopic lesion at the time of surgery is discussed.

Rowell, John T., Milledgeville State Hospital, Milledgeville, Ga. "An Approach to the Treatment of Massive Mental Hospital Populations." MENT. HYG. 39:622-630 (Oct.) 1955.

Milledgeville State Hospital has over 11,000 patients in residence, with at present only a limited staff available to provide them with active care. There is a recognized need for some approach which will give the maximum benefit to these patients by using this limited staff efficiently. This study was undertaken to determine the effect of a ward activation program on the highly regressed patient.

Two wards with similar patient and personnel characteristics were used for this experiment. The building psychologist acting as project director and therapist, introduced a total activation program on the experimental ward, utilizing the cooperation of the ward physician, attendants, and occupational therapist. These activities were directed toward increasing patient interaction. Activities included group psychotherapy, reading and music therapy, games, special occupational and recreational therapy projects and ward improvement committees.

Following six months of concentrated effort, eight patients were furloughed from the experimental ward in contrast to only one from the control ward. In addition, three experimental patients showed marked improvement and one slight improvement. The general level of the experimental ward was raised while little change was observed in the control ward.

physician's bookshelf



Books Received

Modell, Walter, M.D., F.A.C.P., *The Relief of Symptoms*, W. B. Saunders Company, Philadelphia, 1955, 450 pp., \$8.00.

Sterling, Dorothy and Philip, *Polio Pioneers*, Doubleday and Company, Inc., New York, 1955, 128 pp., \$2.75.

The Promotion of Maternal and Newborn Health, Papers presented at the 1954 Annual Conference of the Milbank Memorial Fund, Milbank Memorial Fund, New York, 1955, 229 pp., \$1.50.

Roback, A. A. (Editor), *Present-Day Psychology*, Philosophical Library, New York, 1955, 995 pp., \$12.00.

Van Pelt, S. J., *Hypnotic Suggestion, Its Role in Psychoneurotic and Psychosomatic Disorders*, Philosophical Library, New York, 1956, 95 pp., \$2.75.

Cleckley, Hervey, M.D., *The Mask of Sanity*, The C. V. Mosby Company, St. Louis, 1955, 596 pp., \$9.50.

Eklblad, Martin, *Induced Abortion on Psychiatric Grounds, A Follow-up Study of 479 Women*, Ejnar Munksgaard, Copenhagen, 1955, 237 pp.

Cowdry, E. V., Director, Wernse Cancer Research Laboratory, Washington University, St. Louis, *Cancer Cells*, W. B. Sanders Company, Philadelphia, 1955, 677 pp, 137 fig., \$16.00.

Williamson, Paul, M.D., *Office Procedures*, W. B. Saunders Company, Philadelphia, 1955, 412 pp., \$12.50.

Williams, Robert H., M. D. (Editor), *Textbook of Endocrinology*, Second Edition, W. B. Saunders Company, Philadelphia, 1955, 776 pp., 175 fig., \$13.00.

Lam, Conrad R., M.D. (Editor), *Henry Ford Hospital International Symposium on Cardiovascular Surgery*, W. B. Saunders Company, Philadelphia, 1955, 543 pp., \$12.75.

Tauber, Robert, M.D., F.A.C.S., *Basic Surgical Skills, A Manual with Appropriate Exercises*, W. B. Saunders, Philadelphia, 1955, 75 pp., \$3.75.

Reviews

Cecil, Russell L., M.D., Sc.D., and Robert F. Loeb, M.D., Sc.D., D. Hon. Causa, LL.D. (Editors), *A TEXTBOOK OF MEDICINE*, Ninth Edition, W. B. Saunders Company, Philadelphia, 1955, 1786 pp., \$15.00.

The ninth edition of this *Textbook of Medicine* well justifies its position of leadership in the field. In order to keep pace with the rapid strides which

have been made in medicine during the past four years, 39 new subjects have been covered which were not included in previous editions. The inclusion of this new material along with the expansion of other subjects has necessitated the addition of 150 pages to the text. Coincident with the increased interest in and knowledge of the collagen diseases, this section has been considerably expanded. Other sections have undergone corresponding changes.

The contributors are universally recognized authorities in their respective fields and write with clarity and perspective. Controversial points are avoided, and success is achieved in separating the wheat from the chaff. The physiologic and biochemical aspects of disease are emphasized and an effort is made to correlate these changes with the observed clinical picture. This approach, although attempted in other texts, does not achieve the fine balance in the others that is seen in this edition.

The paper and type are superior. Typographical errors are minimal. Because of its increasing bulk, division of the text into two volumes would probably be advantageous.

This textbook is highly recommended for all students and practitioners of internal medicine.

Greenhill, J. P., M.D., *OBSTETRICS*, Eleventh Edition, W. B. Saunders Company, Philadelphia, 1955, 1088 pp., \$14.00.

Greenhill's eleventh edition of *Obstetrics*, just off the press, consists of 1088 pages and 1170 illustrations, 144 in color and 125 which are new. This edition, like its predecessors, is a full and complete work on obstetrics. It is divided into two parts. Part I has to do with the physiology and development of the ovum. This is a splendid and logical arrangement for teaching medical students the fundamentals in obstetrics. Part II is concerned with the pathology of pregnancy, labor, and the puerperium. This is also an orderly arrangement and well suited for clinical teaching, as well as for reference. As is traditional with Greenhill's former editions, this is a readily readable book. The style is simple, and the subject matter is presented in a very readable manner. Short sentences are used, and the text is accompanied alongside by clear cut pertinent illustrations. The use of large type in double columns to each page makes for easy reading also. The publishers, who are veterans in providing high class text-books over the years, have done their usual good job. The book is not dull as may often be noted in strictly scientific treatises.

In addition to the accepted fundamental knowledge and data, much new material has been added. As one reads, the impression is gained that not only is the knowledge complete, but that it also is the latest and most authoritative on that particular subject. The author, over the years, has had a rich clinical experience and has acquired a vast fund of knowledge. In addition he has an excellent, well trained staff who thoroughly cull the literature, not only from this country, but from many foreign journals as well. Also the experience he and they acquire from editing the *Year Book of Obstetrics and Gynecology* year after year is of immense value in writing and revising a text on obstetrics.

Credit for the assistance given by various specialists for special articles is generously given to them, either directly or indirectly. Only two chapters appear to have been prepared outright by writers other than the author. The bibliography at the end of each chapter is extensive and impressive.

There will be disagreement by some with the emphasis and space given to the use of vaginal cesarean or hysterotomy to empty the uterus in emergencies. It is believed that this operation is rarely used now in most clinics and in modern obstetrical practice. Even in a large service it is doubtful that it would be indicated and done with sufficient frequency to enable anyone to gain a large experience with it.

As would be expected, the use of and importance of local anesthetics is stressed. The author has been a long time advocate of this procedure. The advantages are enumerated and well documented as to safety to be gained by its more liberal use.

Even though the last revision of this work was only four years ago, one is amazed at the number of new chapters and new material added. Some of these are diseases of the nervous system, psychology of pregnancy, labor and the puerperium, induction of labor, prolonged labor, Roentgenology, Rh factor, analgesia and anesthesia, afibrogenemia, endocrine changes, and diseases in pregnancy. New material in regard to the baby most important is probably that regarding retrolental fibroplasia, hyaline membrane, cerebral palsy, asphyxia, and many others.

All in all, the revision of this book has been well done. It is an essential volume for anyone trying to learn, teach, practice, or write about obstetrics.

Charles B. Upshaw, M.D.

Shackelford, Richard T., **BICKHAM-CALLANDER'S SURGERY OF THE ALIMENTARY TRACT**, W. B. Saunders Company, Philadelphia, 1955, 2575 pp., \$60.00 (set of three volumes).

Using an entirely original pattern for a reference work of this type, Shackelford and his associates (few but well chosen) have come forth with an outstanding production, presented in three convenient-

sized volumes. All operations currently in use for surgical conditions of the alimentary tract are adequately described, avoiding excess verbiage and in a clear, concise manner. These include many new procedures that actually were developed while the revision of the book was in progress.

Shackelford's valuable contribution has been the addition of pertinent non-operative information and comments about each surgical condition along with the conventional technics of the operations. This varies considerably and includes comments on surgical anatomy, physiology, pathology, preparation for surgery, post-operative care, and choice of anesthetics. The latter adds little, if any, value because better trained anesthesiologists are making their own selections based on their ability and experience. Those surgeons who find themselves in disagreement with the author's views will admire his courage in putting them down in writing for surgeons to consider (and criticize).

In addition to the organs directly concerned with digestion, many others with only indirect or even remote connection are included in this great work. It was a pleasant surprise to find hernias and hemorrhoids, as well as surgical conditions of the spleen and diaphragms described in detail, and one wondered how the salivary glands, mouth, and pharynx were not included.

The publishers have done their part by using readable type, well selected paper stock, and a format pleasant to follow. There are 2575 pages and 1705 illustrations presented. The illustrations have been strategically placed to make the text easier to follow, and the reproductions are satisfactory.

Regardless of age, these books belong on every surgeon's shelf where they can be used for frequent reference and consideration.

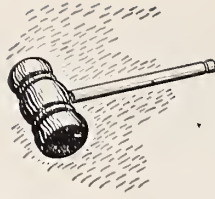
David Henry Poer, M.D.

COLLECTED PAPERS OF THE MAYO CLINIC AND THE MAYO FOUNDATION, Vol. XLVI—1954, W. B. Saunders Company, Philadelphia, 1955, 843 pp., 189 figures, \$12.50.

The 1954 volume of the *Collected Papers of the Mayo Clinic* is a bound volume of summaries of all the articles published in 1953 by staff members of the Mayo Clinic and men in training there. The book has an index by systems which is valuable for the reader who wishes to read several articles on a particular part of the body. In addition, there is an excellent index by authors and by subject. The articles are summaries of longer papers published in various journals; this term is somewhat misleading in that they are longer than the average summary, and contain all the data in the original publication. This is an excellent volume for anyone who wishes to brush up on recent articles on a specific subject.

Duncan Shepard, M.D.

president's page



THIS AUTUMN HAS KEPT ME on the go more than I had ever thought possible. At least the better part of one day each week has been given to some type of organized medical activity. I have enjoyed meeting with every group. Each meeting has left me with impressions that I feel should receive special comment, but this would require too much time and space.

The afternoon spent with the Georgia Association of General Practitioners assembled at the Bon Air in Augusta was most inspiring. The entire program was geared to the greatest needs of the sick where illness first strikes. I wish, however, to single out the address, "Let the People Behold You," by Mr. Mac F. Cahal, the Secretary and Counsel for the American Association of General Practitioners. One could not help but realize how completely the future of medicine rests in the hands of the general practitioner and how earnest this group is in extending their services not only to the whole patient but also to our whole social structure. Any limits on their medical activities by hospitals or medical subdivisions only invite further competition from those with less training but too often inspired with a dogma that has a special appeal to the unthinking and the uninformed.

I trust that the general practitioners of Georgia through their association can have this address reprinted and circulated to every doctor in Georgia. I, myself, in particular would like to read it in addition to having heard it.

H. D. Allen, Jr.

Report of the MAG Maternal and Infant Welfare Committee

AS REPORTED IN THIS *Journal* previously the Committee on Maternal and Foetal Mortality has spent the last year gathering information about maternal and foetal deaths in Georgia.

It was our hope that by accumulating this material we might understand the causes of these deaths and how we might better be able to prevent them.

We began the study by accumulating all death certificates reported during 1954 and sending detailed questionnaires to all parties involved, i.e., doctors, hospitals, nurses, midwives, and public health authorities. These records were kept anonymous by removing the names and places from each record.

The committee then analyzed each death and made an honest effort in every case not only to determine the cause of death, but also to ascertain whether it was preventable or non-preventable. If it were thought that the death could have been prevented; then the source of failure was determined if possible.

This report includes an analysis of the maternal deaths in Georgia from January 1, 1954, through December 31, 1954. All deaths associated with pregnancy were investigated regardless of the length of gestation and including a period of three months postpartum.

The total number of cases reported was 134—of these 28 were considered to be unrelated to obstetrics, i.e., automobile accident, generalized carcinomatosis, etc. This left 106 cases in which questionnaires were sent out to the parties involved.

Of the 106 questionnaires sent out, only 66 were returned or contained sufficient data for analysis. This is a poor response on the part of the physicians, hospitals, and midwives of the state. It is our belief, however, that when all responsible parties understand that we are making an honest effort to improve obstetrical care in the State of Georgia and have no desire to belittle the integrity, judgment, or ability of anyone, that everyone concerned will cooperate with us wholeheartedly in answering all questions in as complete detail as possible.

This report then concerns itself with the 66 cases which were adequately enough reported to be analyzed by the committee. The causes of death in these cases were broken down into seven principal categories:

- A. Hemorrhage—24 cases, including hemorrhage of abortion, ectopic pregnancy, and more advanced pregnancy.
- B. Toxemia—13 cases, which include both the acute and chronic types.
- C. Infection—6 cases.
- D. Pulmonary Embolus—5 cases.
- E. Heart Disease—3 cases.
- F. Anesthetic Deaths—2 cases.
- G. Miscellaneous causes—13 cases.

A total of 16 autopsies were performed in the 66 cases reported.

A careful analysis of the 66 cases by the committee leads them to believe that 48 might have been prevented, that 16 were not preventable, and that six cases were

not obstetrical. The preventable cases showed deficiencies in obstetrical judgment, inadequate hospital facilities, insufficient use of blood, and in some cases serious dereliction on the part of the patient and/or family in seeking medical care.

Summary

1. There were 134 death certificates reported in which a pregnant patient was involved in Georgia in 1954. Of these six were considered to have no relation to the pregnancy.

2. Of the 134 deaths which were investigated, in only 66 instances did the physician and/or midwife see fit to return our questionnaires, and many of these were not completed in full detail. It is the committee's hope and earnest desire that this information be more carefully and completely given in the future.

We must all work together to decrease these deaths by establishing more and better blood banks, by providing more adequate hospital facilities, by better education of the public in seeking earlier and proper medical attention and by better placement and education of our practicing physicians.

3. The two primary causes of maternal deaths in Georgia in 1954 were hemorrhage and toxemia.

4. More autopsies are needed so that the cause of death may be adequately determined.

MAG Maternal and Infant Welfare Committee

Council of the MAG

Thomasville, December 17, 1955

J. W. CHAMBERS, chairman, called to order the regular meeting of the Council of the Medical Association of Georgia at 4:30 p.m., December 17, 1955, at the Scott Hotel, Thomasville.

The following were present: H. Dawson Allen, Milledgeville; Hal M. Davison, Atlanta; David Henry Poer, Atlanta; George R. Dillinger, Thomasville; W. G. Elliott, Cuthbert; J. W. Chambers, LaGrange; Mark S. Dougherty, Jr., Atlanta; Henry H. Tift, Macon; D. Lloyd Wood, Dalton; Neal F. Yeomans, Waycross; H. L. Cheves, Union Point; J. G. McDaniel, Atlanta; C. H. Richardson, Sr., Macon; Edgar Woody, Jr., Atlanta; and Mr. Milton D. Krueger, Atlanta.

Chairman Chambers called on George T. Harrell, Dean of the College of Medicine of the University of Florida, to present to the Council the plan and policy for operation of the new medical school at the University of Florida.

Mr. Krueger read the minutes of the Council meeting, September 11, 1955; the Executive Committee of Council meeting, October 4, 1955; and the Executive Committee of Council meeting, November 3, 1955. The minutes were approved as read.

C. H. Richardson, AMA Delegate, reported on the AMA Boston meeting held November 29-December 2, 1955. Dr. Richardson briefly discussed important measures brought to the attention of the House of Delegates: House Bill 7225; Social Security inclusions concerning M.D.'s; GP recognition and status in hospitals; Grievance Committee stimulation measures; proposed revision of the Code of Medical Ethics; consideration of raising AMA dues \$10.00, allocating that amount to the American Medical Education Foundation; the resolution opposing any M.D. branch of medicine's being split into technician and medical service.

Henry Tift reported for the Council Committee on Reserve Fund Investment. Dr. Tift's report presented the recommendation that part of the Association Reserve Fund be reinvested in larger interest-bearing securities by the Trust Company of Georgia which would act as administrator of the fund in consultation with the Council. Council asked the present committee to recommend a Reserve Fund maximum which after Council approval would automatically be referred to the House of Delegates for final action.

Chairman Chambers called on David Henry Poer to report on the present status of the MAG pension fund. The Reserve Fund Committee was asked to clarify policy on the MAG pension fund and report back to Council and then to the Constitution and By-Laws Committee.

Chairman Chambers called on Hal Davison to report for the subcommittee of Council handling the Association Legal Counsel problem. Mr. Krueger was instructed to discuss the matter of legal advice for members, societies, or the Association with Mr. Dunaway, MAG Legal Counsel, before authorizing any activity by him in behalf of the above parties.

The report of the Council Committee on Cultists was then given by George Dillinger. The report was approved as read.

The meeting was recessed at 6:30 p.m.

December 18, 1955

MEMBERS OF THE COUNCIL present at the reconvened meeting of the Council were Lee Howard, Savannah, and Charles G. Brown, Guyton, in addition to those present on December 17, 1955.

Council Chairman Chambers called the recessed meeting to order at 8 a.m. Mark S. Dougherty, member of the Audit and Appropriations Committee, presented the report of that committee, the 1956 tentative budget for the Association. This was approved as presented with two changes.*

Chairman Chambers called on Mr. Milton Krueger for discussion of provisions for medical defense for members as stated in the MAG Constitution and By-Laws. It was recommended that the Legal Counsel Committee of Council clarify and make recommendations to the Council. These recommendations, if approved, would then be passed on to the Constitution and By-Laws Committee.

Chairman Chambers called on Mr. Krueger for recommendations to the Constitution and By-Laws Committee on Hospital Committee and Audit and Appropriations Committee names. Mr. Krueger stated that he wanted Council recommendations for changing the name of the Audit and Appropriations Committee. It was moved that the Hospital Committee be changed to Hospital Relations Committee and that the Audit and Appropriations Committee be changed to Finance Committee and the Public Relations Committee be known as the Public Service Committee. These motions were passed and the recommendations sent to the Constitution and By-Laws Committee for action. Dr. Chambers then called on Mr. Krueger for the proposal on interprofessional council (M.D.'s, D.D.S.'s, and Pharmacists). Mr. Krueger presented a letter from Mr. D. O. Pierce, Jr., Chairman of the Professional Relations Committee of the Georgia Pharmaceutical Association, recommending

that efforts be made to establish an interprofessional council composed of physicians, dentists, and pharmacists. It was moved that the Association approve this interprofessional council and actively support it. Mr. Krueger then presented a letter from Dean M. A. Chambers, of the Southern College of Pharmacy, asking for cooperation in making available to the Southern College of Pharmacy the MAG mailing list for a questionnaire to be sent these members concerning interprofessional relationships. It was recommended that the Association cooperate fully with Dean Chambers.

It was moved that Council elect a committee for liaison with the Georgia Hospital Association and the Georgia Nurses Association and that this committee be a Council committee.

Chairman Chambers called on Secretary Poer to discuss the matter of State agency nominations submitted by the Medical Association of Georgia. It was recommended that the Governor be asked for clarification on this matter.

Chairman Chambers asked Dr. Poer about a councilor and vice-councilor visitation program. Dr. Poer explained that many of the county societies are extremely interested in having the district councilor and/or vice-councilor visit with them during their society meetings. It was agreed that the councilors and vice-councilors should make all efforts to visit the societies in their respective districts and that Mr. Krueger write each county society president and secretary informing them that they would be pleased to receive invitations to the county society meetings.

Mr. Krueger read the report submitted by Mental Health Committee Chairman Rives Chalmers on the committee's activity to date. It was moved that the report be approved and that the committee be commended for their high degree of activity and excellent appraisal of the Mental Health Problems in Georgia. It was also recommended that the matter of a page in the *MAG Journal* for the Mental Health Committee be referred to the Publications Committee and *Journal* Editor.

Mr. Krueger discussed the mechanism of handling the Hardman Award and the "GP of the Year" Award. He explained that, although this might come under the jurisdiction of the Awards Committee, it had in the past been handled by the Council. It was moved that the Council appoint a permanent committee of Council to handle these two awards as follows: (1) Hardman Award—Council committee to accept all nominations and present three names to the Council for the election of one of these to receive the Hardman Award. (2) That the committee receive nominations for the "GP of the Year" Award to be presented at the first meeting of the House of Delegates. From these and nominations from the floor, the House of Delegates would elect the "GP of the Year" by secret ballot.

Chairman Chambers called on Mr. Krueger for data on the 52nd Annual Congress on Medical Legislation and Licensure to be held February 11-14, 1956, at the Palmer House, Chicago. It was moved that Dr. Chambers, or an alternate, attend this meeting at the expense of the MAG.

A resolution submitted by Lee Howard, Savannah, MAG councilor; J. J. Clark, Atlanta, representative of the Georgia Radiological Society; Warren B. Matthews, Marietta, Darrell Ayer, Atlanta, representatives of the

(Continued on next page)

* The budget is available to any member interested in reading it, upon request to the executive secretary.

ATLANTA, GEORGIA, December 7, 1955 — Dr. Hal M. Davison (right), President-elect of The Medical Association of Georgia, joins his Co-Chairmen of the Atlanta Round Table of The National Conference of Christians and Jews, in welcoming Miss Cornelia Otis Skinner to Atlanta for a luncheon meeting of the organization.

Dr. Davison served as toastmaster, and Miss Skinner's topic was "What You and I Can Do for Brotherhood." Left to right are Mr. A. J. Weinberg and Mr. Laurent deGive.



Council of the MAG (cont.)

Georgia Association of Pathologists; and Lester Rumble, Jr., Atlanta, representative of the Georgia Society of Anesthesiologists, reads as follows:

"On December 15, 1955 at a meeting of a Joint Committee composed of Representatives from the Georgia Association of Pathologists, Georgia Society of Anesthesiologists, and Georgia Radiological Society, the following resolution was approved by this group for presentation to the Council of the Medical Association of Georgia requesting subsequent action as designated in the resolution.

"WHEREAS, the American Medical Association has stated that the practice of anesthesiology, radiology and pathology constitute the practice of medicine, and

"WHEREAS, the Medical Association of Georgia by its Constitution fully accepts the AMA Code of Ethics which incorporates this principle, and

"WHEREAS, the Medical Association of Georgia has repeatedly established its strong opposition to the corporate practice of medicine as being unethical, and

"WHEREAS, violations of these principles are becoming more numerous, not only in the three specialties undersigned, but in the general field of medicine, and

"WHEREAS, the time is long past where action by small groups of individuals are effective;

"THEREFORE, BE IT RESOLVED, that the Council of the Medical Association of Georgia appoint a special five man committee to function under the direction of the Council and report back to the Council and

"NOW, THEREFORE, BE IT FURTHER RESOLVED, that the Committee's primary purposes and objectives should be as follows:

"(1) To collect facts about situations prejudicial to ethical physician-institutional arrangements.

"(2) To serve as a preliminary fact-finding body in the consideration of controversies in this field.

"(3) To compile for publication brief factual summaries of situations as they exist.

"(4) To follow the direction of the Association's legal representation in keeping these facts in such form as to be useful by legislative committees.

"(5) To periodically make recommendations de-

signed to solve problems of local interest; and to eventually effect a legal solution to the problem of the corporate practice of medicine in Georgia."

It was suggested that this committee be composed of one MAG member from each of these three specialty groups (to be recommended to Council by these groups), a member from Council, and a member-at-large.

It was moved that this resolution be adopted by the Council and the request in the resolution be adhered to by the Medical Association of Georgia in toto.

Chairman Chambers then called upon Secretary Poer to discuss a "medical school's code of cooperation." Dr. Poer read a rough draft of a proposed code of cooperation pertaining to the operation of medical school facilities. After discussion it was moved that the Executive Committee draft this proposed code of cooperation and refer it to the full Council for approval.

Mr. Kiser presented a report of legislative activity in behalf of the Association.

A rising vote of thanks was given by all members of Council to Dr. and Mrs. Dillinger and the Thomas-Brooks County Medical Society as represented by Kirk Shepard and Julian Neel.

Council then went into executive session to discuss the matter of present and future salaries for the elected secretary-treasurer. It was decided to leave the fixed salary at the amount listed in the budget and to make proper adjustments at the end of the year. This was done for 1955 and notification sent to the auditors. Secretary Poer discussed plans for decreasing the amount of time required by the duties of this office and increasing the responsibilities of the executive secretary and his staff; a satisfactory program was agreed upon.

Council approved the action of the Executive Committee making David Henry Poer Editor-in-Chief of the *Journal*. Council also approved the committee's decision to give Blue Cross-Blue Shield health insurance coverage to all Association employees.

The Executive Committee was directed to set the time and place for the next regular meeting of Council. Dr. Howard extended an invitation for this meeting to be held in Savannah; this was referred to the Executive Committee.

Meeting adjourned.

ANNOUNCEMENTS

American Congress of Physical Medicine and Rehabilitation Annual Prize Lecture—Prize for an essay on any subject relating to physical medicine and rehabilitation. Primarily directed to medical students, interns, residents, and graduate students. Manuscripts must be in the office of the ACPMR, 30 North Michigan Ave., Chicago 2, Ill., not later than June 1, 1956. Manuscripts must not exceed 3000 words and the number of words should be stated on title page. Winner receives a cash award of \$200, a gold medal, certificate, and invitation to present the contribution at the 34th Annual Session of the Congress, September 9-14, 1956, at the Ambassador, Atlantic City, N. J. For further information, write to the executive secretary, Dorothea C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Ave., Chicago 2, Ill.

Medical Officers, U. S. Public Health Service Regular Corps Examinations—Competitive examination for appointments will be held throughout the country on March 20, 21 and 22, 1956. Entrance pay for Assistant Surgeon with dependents is \$6,017 per year; for Senior Assistant Surgeon with dependents, \$6,918. Application forms may be obtained from the Chief, Division of Personnel, Public Health Service, Dept. of Health, Education, and Welfare, Washington 25, D. C. Completed application forms must be received in the Division of Personnel no later than February 10, 1956.

Atlanta Graduate Medical Assembly—February 20-22, 1956, Atlanta Biltmore Hotel, Atlanta, Ga. Speakers include Philip K. Bondy, M.D., Woodbridge, Conn.; Charles C. Harold, M.D., New York City; Theodore Winship, M.D., Washington; Russell L. Dicks, D.D., Durham; Willis J. Potts, M.D., Oak Park, Ill.; Clyde L. Randall, M.D., Buffalo; Alexander D. Langmuir, M.D., Atlanta; Jack D. Myers, M.D., Pittsburgh; Charles H. Hendricks, M.D., Cleveland; Ralph B. Cloward, M.D., Honolulu; Arnall Patz, M.D., Baltimore; Ivan L. Bennett, Jr., M.D., Baltimore; Meredith F. Campbell, M.D., Miami; Philip Thorek, M.D., Chicago; Samuel Kaplan, M.D., Cin-

cinnati; Wilburt C. Davison, M.D., Durham; George Saslow, M.D., Newton Highlands, Mass.; Fred J. Hodges, M.D., Ann Arbor; and Walter Lillehei, Ph.D., Minneapolis. For further information write to the Atlanta Graduate Medical Assembly, 15 Peachtree Place, N.W., Atlanta, Georgia.

Fifth Congress of Pan American Medical Women's Alliance—Santiago and Vina del Mar, Chile, March 6 to 14, 1956. Opportunities for sightseeing and visits to medical programs in Mexico, Salvador, Panama, Chile, Bolivia, and Peru have been arranged. Information may be obtained from the secretary, Dr. Eva F. Dodge, 2124 West 11th Street, Little Rock, Ark., or from the program chairman, Dr. Eva Cutright, Wooster, Ohio.

Hawaii Medical Association Centennial Celebration and Scientific Congress—Honolulu, April 22 to 29, 1956. Every physician in the U. S. is invited to celebrate the centennial with the Hawaii Medical Association. There will be a short but worthwhile professional program on Monday and Tuesday mornings, Centennial Celebration Pageant Tuesday night, and a traditional luau (Hawaiian feast) Thursday night, with Polynesian entertainment. Tours are planned for each day of the meeting. For information and reservations write to the Hawaii Medical Association, 510 South Beretania St., Honolulu 13, Hawaii.

First International Symposium on Venereal Diseases and the Treponematoses—Statler Hotel, Washington, D. C., May 28-June 1, 1956. Sponsored by the U. S. Dept. of Health, Education, and Welfare, and the World Health Organization. The symposium is open to all physicians, scientists, and professional health workers interested in participating. Anyone interested in submitting a paper for consideration by the program committee should send an abstract of his paper to Dr. C. A. Smith, Medical Director, Chief, Venereal Disease Program, Division of Special Health Services, Public Health Service, Dept. of Health, Education and Welfare, Washington 25, D. C. before February 1, 1956.

DEATHS

WILLIAM B. ARMSTRONG, Atlanta, died December 2, 1955, at a hospital in Philadelphia. He had been ill for two years.

Dr. Armstrong was the son of the late Dr. and Mrs. William B. Armstrong of Atlanta. He attended Atlanta public schools, the University of Georgia, and Emory University School of Medicine. An ear, nose, and throat specialist, Dr. Armstrong received graduate training at Duke University Medical School. During World War II he served overseas with the Emory Unit.

He was a member of the Chi Phi social fraternity and the Piedmont Driving Club of Atlanta.

Dr. Armstrong is survived by his wife, the former Miss Henrietta Collier of Atlanta, and a daughter, Miss Henrietta Armstrong also of Atlanta.

SOCIETIES

THE SIXTH DISTRICT MEDICAL SOCIETY met on November 30, 1955, at the Georgia Power Company Building in Macon. Charles H. Richardson, Jr., Macon, president, presided. The scientific program had the following speakers: Waddell Barnes, M a c o n — "Differential Diagnosis of Obstructive Jaundice"; Arthur Merrill, Atlanta—"Clinical Electrolyte Problems; and Lowrey Davenport, Macon—"Discombobulation: A Therapeutic Concept as Applied to Steroid Imbalance." Discussors for these papers were Calder Clay, Jr., Ralph Newton, Jr., and Leon Goodman. At the business meeting which followed, John A. Bell, Jr., Dublin, was elected president of the society. Social hour, square dance, and dinner at the Idle Hour Country Club followed the meeting.

THE BARTOW COUNTY MEDICAL SOCIETY held its quarterly meeting in December 1955 at the Cartersville Country Club. New officers elected for 1956 are as follows: L. Ross Whatley, Cartersville, president; J. W. Stanford, Cartersville, vice-president; A. L. Horton, Cartersville, secretary; and W. B. Quillian, Cartersville, delegate.

THE FULTON COUNTY MEDICAL SOCIETY acted as host to the Atlanta group viewing the nationwide, closed circuit television program telecast from the clinical sessions of the AMA meeting in Boston in November. The program was produced by

Smith, Kline and French Laboratories with the cooperation of the AMA and had an audience of approximately 25,000 physicians gathered at viewing locations across the nation.

The MUSCOGEE COUNTY MEDICAL SOCIETY met at the Standard Club in Columbus on November 22, 1955, to elect new officers. Hugh Bickerstaff, Columbus, was installed as president and the following officers were elected: Clarence Butler, president-elect; Roy Gibson, delegate; and Jack Davidson, alternate delegate. Harry Brill was appointed editor of *The Muscogee Medical Society Bulletin*. Speaker at the meeting was Mr. John Kiser, Assistant Executive Secretary of the MAG. Other guests included State Senator Howell Hollis and Representatives Mac Pickard, J. Gordon Young and John Nilan.

At the November meeting of the RICHMOND COUNTY MEDICAL SOCIETY, James G. Arnold, Jr., Baltimore, spoke on "Some Neurological Manifestations of Cervical Spine Disease." Dr. Arnold is a native of Atlanta; he received his education at Furman University and Johns Hopkins Medical School, and he has done postgraduate work at Baltimore City Hospital, the University of Maryland, and the University of London. He is at present Professor and Chairman of the Department of Neurologic Surgery at the University of Maryland.

The SOUTHWEST GEORGIA MEDICAL SOCIETY held its annual meeting in Edison on November 16, 1955, at the home of Dr. and Mrs. J. B. Martin. Officers for 1956 were elected: J. B. Martin, president; Warren Baxley, Blakely, vice-president; J. H. Crowdis, Blakely, secretary-treasurer; and James B. Martin, Edison, delegate.

The WARE COUNTY MEDICAL SOCIETY held its annual Christmas meeting at the Woman's Club, Waycross, on December 1, 1955. Dr. and Mrs. W. E. Reavis and Dr. and Mrs. Lovick Pierce were hosts. Officers elected for 1956 are as follows: Floyd E. Davis, Waycross, president; W. B. Bates, Jr., vice-president; and Arthur M. Knight, Jr., secretary-treasurer. Delegates named were W. L. Pomeroy and Leo Smith; alternates are Ansley Seaman and Vilda Shuman. Guests at the meeting were Dr. and Mrs. G. W. Bark-

er, St. Marys; Dr. and Mrs. Shannon, ACL Hospital, and Dr. and Mrs. T. K. Hill, Santa Barbara, Cal.

The WILKES COUNTY MEDICAL SOCIETY held its regular monthly meeting in November. Paul Keller, Athens, spoke on hearing difficulties. Other guests included John Phinzy, Lincolnton; Harry Cheves, Sr., and Harry Cheves, Jr., Union Point; Albert LeRoy, Thomson; and Henry Alston, Thomson.

PERSONALS

First District

A charter has been obtained for the erection of a medical center consisting of buildings for offices and laboratories to be occupied by practicing physicians and dentists in Savannah. The physicians are as follows: THOMAS A. AMBURGEY, LAWRENCE S. BODZINER, DARNELL L. BRAWNER, VINCENT J. CIRINCIONE, DAVID B. FILLINGIM, HENRY C. FRECH, JR., GRANT W. GOLDENSTAR, ROBERT B. GOTTSCHALK, FRANK HOFFMAN, LEE HOWARD, SR., LEE HOWARD, JR., DEARING A. NASH, FENWICK T. NICHOLS, JR., W. L. OSTEEEN, HARRY J. PORTMAN, DAVID ROBINSON, EMANUEL F. ROSEN, W. LAWRENCE SALTER, MEYER M. SCHNEIDER, HAROLD M. SMITH, RICHARDSON L. STONE, JULES VICTOR, JR., C. W. WESTERFIELD, and JOHN G. ZIRKLE.

RALPH O. BOWDEN, Savannah, was elected president of the medical staff at Telfair Hospital at the annual Christmas dinner meeting of the staff.

Gabriel D'Amato, former medical officer at Hunter Air Force Base and now medical director of the Mental Health Clinic of the Chatham-Savannah Health Center, has opened an office at 228 E. Huntingdon Street for the private practice of psychiatry. He will devote half his time to the clinic and the remainder to private practice. Dr. D'Amato is a native of New York; he graduated from Seton Hall University and the Columbia University College of Physicians and Surgeons. He is a diplomate of the National Board of Medical Examiners. He received his psychiatric and psychoanalytic training at the Bronx, VA Hospital and at Creedmoor State Hospital, Long Island, N. Y.

WALDO E. FLOYD, Statesboro, has been elected Director of the Board

of American Family Life Insurance Company, a recently chartered company with home offices in Columbus. Dr. Floyd is a graduate of the Medical College of Georgia and is engaged in the active practice of medicine and general surgery in Statesboro.

HENRY C. FRECH, Savannah, announces the association of L. Richard Lanier, Jr., Savannah, in the practice of obstetrics and gynecology with offices at 427 Bull Street, Savannah.

J. C. METTS, Savannah, took part in the Pearl Harbor Day exercises of George K. Gannam Post 184, American Legion, on December 4, 1955. He introduced the speaker, former governor Herman Talmadge. Dr. Metts is chief of staff of Memorial Hospital, which stands as a memorial to Chatham County's war dead.

Second District

No news received.

Third District

FRANCIS WARD, Fitzgerald, spoke on the relationship of physical and mental health at a recent meeting of the First Ward Parent-Teacher Association, in Fitzgerald.

Fourth District

AUGUSTUS H. FRYE, JR., Griffin, is taking a three year leave of absence to take his residency training in orthopedic surgery in Chattanooga.

Fifth District

MILTON F. BRYANT, JR., Atlanta, has been appointed an instructor in surgery of Emory University School of Medicine. Dr. Bryant has recently come to Atlanta after service in the U. S. Army Medical Corps in Japan. He is a native of Blakely; he graduated from Mercer University and the University of Michigan Medical School. He also holds the M.S. degree in surgery from the University of Michigan and is a diplomate of the American Board of Surgery. Dr. Bryant is in the private practice of surgery at 1211 West Peachtree Street, N.E., Atlanta.

DON CATHCART, Atlanta, and Mrs. Cathcart returned to their home in Atlanta a week before Christmas from a visit to their daughter and son-in-law in Los Angeles, Calif. The Cathcarts are proud new grandparents, and this trip was to meet the newest member of the family.

ROGER W. DICKSON, Atlanta, has

recently been made an honorary member of the Gridiron Society at the University of Georgia. Gridiron is a Senior Society at the University.

WILLIAM G. HAMM, Atlanta, has been promoted to rear admiral in the U. S. Naval Reserve. It is rumored that the new admiral has hanging in his library at home the most unusual plastic surgeon-admiral's flag in captivity. In fact it is probably unique; what other admiral's flag has Jimmy Durante's nose and anonymous warts embroidered thereon?

Attending the Georgia-Florida Radiological Society meetings in St. Simons Island in November were the following Atlanta physicians and their wives: TED F. LEIGH, ALBERT A. RAYLE, JR., FRANK WALKER, STEVEN CLINE, ERNEST SMITH, WILLIAM BRYAN, and JAMES V. ROGERS, JR.

JOHN R. LEWIS, Atlanta, related his experiences as a naval medical officer at Pearl Harbor during World War II at the November meeting of the Atlanta Writers' Club.

J. ELLIOTT SCARBOROUGH, Atlanta, has been named to the national Board of Directors of the American Cancer Society. Dr. Scarborough, director of Emory University's Winship Clinic, is chairman of the Executive Committee of the Georgia Division of the American Cancer Society and is a member of the cancer committee of the American College of Surgeons and the National Advisory Cancer Council.

JOSEPH S. SKOBBA and PAUL L. SCHROEDER, Atlanta, announce the association of Robert J. Van de Wetering with them in the practice of psychiatry. Dr. Van de Wetering is a native of Bellingham, Washington; he received his M.D. degree from the University of Tennessee. He served his residency in psychiatry at the U. S. Naval Hospital in San Diego and the University of Indiana.

Dr. and Mrs. W. A. SELMAN, Atlanta, celebrated their fiftieth wedding anniversary at a party given by their sons and daughters, Mr. and Mrs. Eugene Craig and Dr. and Mrs. Edwin Cathell, at the Druid Hills Gold Club on November 15, 1955.

The Public Health Service of the Department of Health, Education, and Welfare has announced the appointment of 86 physicians, nurses, sanitary engineers, dentists, and pharmacists to the inactive reserve component of its commissioned officer corps. One of these is from Georgia: JOHN H. VENABLE, Atlanta. Dr. Venable holds the rank of senior surgeon (equivalent to the Navy rank of commander). Dr. Venable is Director of Training for the Georgia Department of Public Health.

Sixth District

HOWARD J. WILLIAMS, Macon, was elected to fellowship in the American Academy of Pediatrics at the September 28th meeting in Chicago.

Seventh District

BILL PURCELL, Calhoun, has been elected chief of staff of the Gordon County Hospital succeeding J. E. BILLINGS. Elected to serve with Dr. Purcell were LEWIS LANG, assistant chief of staff, and GORDON JACKSON, secretary. They took office January 1, 1956.

HARLAN M. STARR, Rome, has been made a fellow of the American Academy of Pediatrics.

Eighth District

JAMES M. HICKS, Brunswick, has completed a 10 day course in plastic surgery at the Manhattan General Hospital for which he was awarded a certificate by the American Academy of Plastic Surgery in New York in November.

VILDA SHUMAN, Waycross, has been appointed chairman of the South Atlantic District of the Pan American Medical Women's Alliance. (See Announcements)

TOM STAPLETON, Pearson, is the head of the new Pearson City Medical Clinic. The clinic was dedicated on December 4, 1955, and open house was held at the Atkinson County High School for all visitors from different sections of the country.

Ninth District

JOHN H. CARSWELL and JOHN W. ACREE, Hiawassee, will operate a clinic in Helen three afternoons a week it has been announced. Both doctors, associated in private prac-

tice in Hiawassee and also on the staff of the Memorial Hospital, are on call at Helen. They are using the office building formerly occupied by T. N. LUMSDEN, now of Clarkesville.

JOSEPH ROBERT CHASTAIN, Buford, is the new medical director at Pacolet Mill No. 4, New Holland. He succeeds H. H. LANCASTER who resigned from office after 15 years to accept the appointment as Medical officer and commissioner of Hall County's Health Department. Dr. Chastain is a native of Pickens County, a graduate of the Berry Schools, the University of Georgia, and the Medical College of Georgia. He has practiced for the last 15 years in Buford.

Georgia physicians not only got the first Sears Roebuck grant (page 505, *Journal of the Medical Association of Georgia*, October 1955) but the largest of the grants given in the country. The recipients are J. J. WALKER, THOMAS N. LUMSDEN, CHARLES M. HENRY, and L. G. HICKS, JR., of Clarkesville.

JOHN W. MAULDIN, Lawrenceville, attended the recent meeting of the Southern Medical Association in Houston, Texas.

Tenth District

ROBERT B. GREENBLATT, Augusta, was one of the physicians addressing the second annual Graduate Symposium in Geriatric Medicine at Boston in November. Subject of Dr. Greenblatt's address was "Indications for Steroid Hormone Therapy in the Geriatric Patient."

ROBERT C. MCGAHEE, Augusta, was the guest speaker at a joint meeting of the Adult Sunday School classes of Wrens Methodist Church in November. Dr. McGahee is a graduate of Wrens High School and teaches an adult Bible class at St. Johns Methodist Church in Augusta.

V. P. SYDENSTRICKER, of the Medical College of Georgia, has been awarded a grant in the amount of \$3,548 by the National Institute of Arthritis and Metabolic Diseases for research in "Hepatic Disease in Relation to Amino-acid and Vitamin Deficiency." The grant covers the research during the period from January 1 to April 30, 1956.

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COVER

This month we salute the Gray Ladies of the American Red Cross in recognition of the tremendous job they are doing in Georgia. See also page 61. Photo by Ted F. Leigh, M.D.

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(This list can be no more correct than your county secretary makes it. Ed.)

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ON FEBRUARY 10, 1956, Governor Marvin Griffin signed into law House Bill 121 which repeals the Naturopathy Act of 1950.

Meanwhile, H.B. 283, introduced January 25, 1956, in the General Assembly, (which provides that the Regents, Medical College and Talmadge Hospital *shall not* be authorized to make any charge for medical or surgical service or as such engage in the practice of medicine) was referred to subcommittee and has little chance of passage. As a result of this action, there is a strong indication that an equitable solution, satisfactory to all concerned, can be worked out in the near future without legislative enactment.

The Association is grateful to the members of the General Assembly and the Governor for their interest in improving health conditions in Georgia and in maintaining high medical care standards, as evidenced by their support of the Naturopath bill.

The Headquarters Office would also like to take this opportunity to express appreciation to the many members over the state who cooperated in the MAG legislative program this year. Without your support very little could have been accomplished.

Instrumental in securing passage of the Naturopath Repeal Law in the House of Representatives were Representative Cleve Mincy of Waycross and Speaker Marvin Moate of Sparta. Mr. Mincy spent many hours in seeking support for the bill from other members of the House. It was largely due to his friendly and impartial approach to the problem that the bill was allowed to pass the House with no debate. Following Mr. Mincy's short speech explaining the bill, the House voted 115 to 3 to send the bill on to the Senate.

Speaker Moate lent his prestige to the bill by signing as the first author of the measure. Through his influence and persuasion other members of the House supported the bill. Also active in support of

the bill in the House were the following members of the House of Representatives: W. M. Williams of Gainesville; Bill Freeman of Forsyth; Fred Jones, Dahlonga; Alpha Fowler, Douglasville; Bob Harrison, Jesup; Bill Parker, Baxley; Ben Rodgers, Folkston; Robert Chastain, Thomasville; Arthur Bolton, Griffin; Pete Pettey, Hawkinsville, and many, many others.

It goes without saying that we owe considerable thanks to Dr. Grady Coker of Canton and Dr. Marcus Mashburn of Cumming for their work in behalf of the bill.

In the Senate, our sincere thanks go to Floor Leader Howard Overby of Gainesville who led the fight for passage of the bill during a long debate on the floor of the Senate.

Following Senator Overby's concluding speech, the Senate approved the measure to abolish Naturopathy in Georgia by a vote of 37-6.

Dr. C. L. Ayers of Toccoa, Senator from the 31st District, and Senators Cullen Richardson, Montezuma; D. B. Blalock, Newnan; Everett Millican, Atlanta; Glen Florence, Douglasville, and others, were instrumental in securing passage of the bill in the Senate.

Many other organizations cooperated in the campaign to raise health standards in Georgia by eliminating the practice of Naturopathy. The Atlanta Better Business Bureau, headed by Mr. Robert Stephens, together with the Fulton County Medical Society, originally started the campaign. Solicitor Paul Webb of Atlanta was extremely cooperative and helpful as was the Fulton County Grand Jury and the DeKalb County Grand Jury.

Our thanks to Dr. Herman Jones of the State Crime Laboratory who testified at the public hearing on behalf of the Naturopathy bill.

John F. Kiser
Asst. Executive Secretary

WASHINGTON, D. C.: All too frequently overlooked in Congressional activity on health and related bills each year are the little-publicized but highly important appropriations measures—without which no program of the federal government could move forward. The appropriations hearings in the House (where all money bills must originate) rarely get headlines; they are conducted behind closed doors. Weeks and sometimes months later, the hearings are published, but by then the bill supplying money for an agency has been reported to the House.

It's only when the measure gets to the Senate that private groups and individuals are heard—by then in open sessions. Closed House sessions are not new. That is the way it has been done ever since Congress set up a separate committee on appropriations back in 1865.

The importance of appropriations in running the federal government was clearly illustrated when the President submitted to Congress his 1,272-page budget message in which he sought \$65.9 billion for all federal programs for the fiscal year beginning July 1.

While there was no overall total of projected spending by all the agencies in the health field, the budget requests for the Department of Health, Education, and Welfare showed a sharply upward trend. And if certain new legislation is voted on this session—like the projected 5-year program of construction grants for medical schools and private laboratory facilities—the total figure for subsequent years is likely to be even higher.

On the medical school-laboratory construction bill, the President asked Congress for \$40 million for the first year (estimated cost over five years is \$250 million). Construction grants, which would have to be matched on a 50-50 basis, would be available for private medical schools as well as non-federal laboratories conducting research into a wide range of crippling diseases. The budget message also calls for another \$30 million in outright grants to the states to help them in financing poliomyelitis vaccination programs, the same amount appropriated by Congress last session. The administration in a separate request asked for extension of the polio law, from February 15, 1956, to June 30, 1957, and both the House and Senate with only brief debate voted the 17-month extension. Since only half of last year's \$30 million was spent up to the February 15 expiration date of the original act, there was no rush for Congress to act on the new account.

Other new spending asked by the administration, contingent, of course, on enabling legislation, includes \$10 million for initial capitalization of mortgage loan guarantees for health facilities; \$5 million for graduate and practical nurse and professional health personnel training, \$3 million for water pollution grants; \$1.5 million for mental health expansion programs; and \$1 million for sickness and disability surveys in the U. S.

If Congress approves the requests, virtually all segments of the Department of HEW will have more money to spend than in this fiscal year. None would benefit more, however, than the medical research arm of government, the National Institutes of Health. The total sought for the seven institutes is 28 per cent more than estimated spending this year. Here are some examples: National Cancer Institute, \$32,437,000, up 29 per cent; National Heart Institute, \$22,106,000, up 17 per cent, and the National Institute of Allergy and Infectious Diseases (formerly the National Microbiological Institute), \$9,799,000, a 26 per cent increase.

The President requested \$130 million for the Hill-Burton hospital-clinic construction program which will be 10 years old this August. In this connection Congress has been asked to extend the act for two years beyond next year, and action is expected this session.

After a study of possibilities in the peaceful uses of atomic energy, a panel has recommended, among other things, that the U. S. encourage states and private organizations to take full advantage of the opportunities offered by radioactive material for medical research and treatment.

It now appears that an improved and more uniform program of medical care for service families will be adopted this session—possibly before this is published. One feature: A \$25 deductible charge in civilian hospitals, but with the government paying the full insurance premium, and a mandatory subsistence charge in military hospitals.

Making slower progress is the plan—under consideration for more than a year—for a health insurance program for U. S. civilian workers. Here the government would pay about half the cost.

Several committees are urging stricter penalties and other changes to bring the illicit narcotic traffic under better control; so far no suggestion of more controls over the medical profession in the handling of narcotics.

An Evaluation of Early Operation in Acute Inflammation of the Gallbladder

PATRICK C. SHEA, JR., M.D., Atlanta, Ga.

FOR MORE THAN 20 years there has been an increasing tendency to operate on patients during the acute phase of their gallbladder disease. This trend has been accompanied by an increase in reports of postcholecystectomy biliary duct strictures. Furthermore, in many instances, pathological findings have not supported the clinical impression of acute cholecystitis.

With the advent of such important contributions as intravenous fluids, control of acid-base balance, improved anesthesia techniques, there has been a decrease in morbidity and mortality. The high incidence of pulmonary complications and cardiovascular and renal catastrophes continues to pose a serious problem. Although the use of antibiotics apparently has not materially affected the mortality rate, in the series reported here it has certainly decreased the incidence of pulmonary complications.

In evaluating the merits of early operations as opposed to conservative treatment followed by an elective procedure, mortality alone cannot serve as a criterion, since fatalities may occur during the acute stage regardless of whether the treatment is conservative or operative. A comparison of morbidity, complications, surgical trauma, postoperative sequelae, and length of hospitalization in series of patients in both categories should also be made.

The following report is based on 209 consecutive cholecystectomies performed over a three-year period at the Grady Memorial Hospital. All surgical procedures in this series were performed by the resident house staff. All but two of the operations were performed for nonmalignant inflammatory disease of the gallbladder, either acute, chronic, or both. The two patients who had carcinoma of the gallbladder died and are excluded from some, but not all, of the

tabulated data. Eight additional operations performed for gunshot wounds and in conjunction with other procedures (such as pancreatico-duodenectomy) are excluded entirely.

Of the 209 patients, 51 were operated upon within 24 hours of admission to the hospital and during the acute period of their disease. The remaining 158 were first treated conservatively and later subjected to elective cholecystectomy.

Methods

The chief aim in the management of patients with gallbladder disease is to perform the indicated surgery during a period presenting the least jeopardy to life. Every effort is made to tide the debilitated or poor surgical risk patient over the acute period, if possible. The individual treatment of patients with gallbladder disease in this hospital may follow one of three courses:

1. *Early operation*
 - a) for those who give the clinical impression of impending gangrene or perforation, even though they may not otherwise be ideal candidates for surgery, and
 - b) for those with severe manifestations of acute cholecystitis, either static or progressive, whose general health is excellent.
2. *Management with antibiotics, supportive therapy and ultimate elective surgery*—for those who demonstrate manifestations of cholecystitis, but in whom these phenomena are subsiding and whose general health makes elective operation the wiser procedure;
3. *Elective surgery*—for those who show signs and symptoms of chronic cholecystitis.

The 51 patients operated upon within 24 hours of admission were first under observation and preparation for a *minimum* of four to six hours. During this time any indicated diagnostic tests, including

From the Whitehead Department of Surgery, Emory University, and Grady Memorial Hospital, Atlanta, Ga.

electrocardiograms, chest and abdominal x-rays, blood urea nitrogen, serum amylase studies, frequently repeated leucocyte counts, and urinalysis (required of every hospital admission), were performed. The state of hydration was also evaluated and corrected with intravenous fluids and blood, when necessary. Nasogastric suction was instituted, and repeated doses of atropine and barbiturates were administered as necessary. Patients with severe or moderate clinical evidences of peritonitis in the gallbladder region were given penicillin and, in some instances, aureomycin. Narcotics were withheld from all patients with clinical evidence of acute cholecystitis until a definite decision could be reached as to the immediate type of therapy.

Patients whose moderate to marked acute manifestations subsided experienced a resolution or decrease of colicky pain, fever, tenderness, and leucocytosis, in that order, over a period of three to four days. Relief from pain usually occurred within a few hours.

Early operation was indicated in patients who demonstrated the following *in combination*:

1. Progressive and rebound tenderness over the gallbladder region;
2. Continued or heightened fever;
3. Persistent, elevated white blood count;
4. Constant or increasingly severe pain.

When operative intervention was decided upon, demerol was given, and the procedure was instituted within an hour.

All patients were brought to the operating room with functioning nasogastric suction tubes in place. Gas inhalation anesthesia was usually employed; occasionally spinal anesthesia was used, but never local. The patient was placed on the table in such a fashion as to bring the rest of the gallbladder elevator opposite the level of the xiphoid process.

Exposure was obtained through a subcostal incision parallel to the right costochondral margin. The combination of position and exposure used here has been found to expedite and facilitate exposure of the gallbladder and extrahepatic biliary area. Extrahepatic ducts were visualized. The cystic vessels and duct were isolated by dissection and sectioned between ligatures passed about them with a suitable ligature carrier. No instruments were applied to the cystic duct or artery. At the close of the procedure, a Penrose rubber drain was placed with one end just lateral to the foramen of Winslow, and the other end was exteriorized through a separate stab wound in the flank.

A review of this group of 209 patients reveals that 149 were white and 60 were Negroes. It is noteworthy that the incidence of gallbladder disease

among Negroes has increased in the past 15 years.^{1 2} The average age of the white patients was 52.6 years, and of the Negroes, 43.6 years. For the entire group, the average age was 50.1 years, but for those operated upon within 24 hours of admission it was slightly higher—54.7 years. Inflammatory disease of the gallbladder occurred more frequently and was tolerated longer in women than in men. The average age of all male patients was 48.6 years; for the females it was 61.1 years. The age distribution of the group is listed by decades in Table I.

AGE DISTRIBUTION*		
Decades	Total Patients 207	Early Operations 51
10-19	2	0
20-29	18	4
30-39	42	7
40-49	52	9
50-59	39	12
60-69	37	10
70-79	16	8
80-89	1	1

Table I

*Non-malignant cases only.

The history obtained from the patients proved unreliable in diagnosing acute cholecystitis. An impressive number had lived with the insults of gallbladder disease and biliary colic for from one to 10 years, or even longer (Table II). The majority of the patients subjected to immediate operation had been acutely ill for 36 hours before admission, but no longer than five days; yet 63.5 per cent gave histories of one or more prior attacks, and this was confirmed by microscopic examination of the gallbladders.

PREVIOUS HISTORY OF GALLBLADDER DISEASE		
Initial Onset of Symptoms	Elective Operations (158)	Early Operations (51)
Silent	13	1
2 days, or less	4	13
2 days to 2 months	29	9
2 months to 1 year	32	12
1 to 10 years	62	11
Over 10 years	18	5

Table II

The pathological findings in the 209 gallbladder examinations are given in Table III. Among the 51 patients with early cholecystectomies, the diagnosis

of acute or acute and chronic cholecystitis was returned in 41 cases (82 per cent). The gallbladders of 28 of the elective patients (17.7 per cent) also showed acute and chronic inflammation. This is understandable because a number of patients who displayed moderate to profoundly acute manifestations upon admission responded to conservative management and could be better evaluated and rehabilitated for elective surgery at a later date.

PATHOLOGICAL FINDINGS IN 209 GALLBLADDERS			
Acute cholecystitis			69
Acute only	(12)		
Acute and chronic	(57)		
Chronic cholecystitis			135
Autolyzed, containing stones			3
Carcinoma			2

Table III

A comparison of the degree of leucocytosis with the pathological diagnosis showed many discrepancies. Although the average leucocyte count in patients operated upon within the first 24 hours was 15,100 cells per cu. mm., and 8,600 in those having elective procedures, anomalous counts occurred in 20 to 25 per cent of the cases. Among the 69 patients on whom the pathologist returned a diagnosis of acute cholecystitis, 17 (four early and 13 elective), or 24.6 per cent, had a leucocyte count below 10,000 per cu. mm. On the other hand, among the 135 patients whose gallbladders showed chronic inflammation, 28 (four early and 24 elective), or 20.7 per cent, had leucocyte counts of over 10,000 per cu. mm.

This supports Bailey's observation that the leucocyte count is not reliable in differentiating between acute and chronic cholecystitis.³ The progressive increase or decrease in white blood cells on repeated determinations is of value, however. In patients with leucocyte counts of 25,000 to 35,000, it is often observed at operation that perforation appears imminent and the gallbladder wall is frequently either gangrenous or the site of intramural abscesses.

The presence of a mass could not always be depended upon to substantiate the diagnosis of acute cholecystitis, its progress, or its regression. In many patients a right upper quadrant mass was palpable; in others it was not sharply delineated because of spasm, rigidity, or tenderness. The changing size of a palpable mass, however, was of help in indicating a plan of therapy.

Mortality

All deaths occurring in the hospital, regardless of the post-operative date, were considered as operative in this series. In the 207 cholecystectomies for non-

malignant inflammatory disease, six fatalities occurred. A review of the cause of death suggests that in most instances the terminus could have been the same even without operative intervention. It is further conceivable that the mortality rate in the 51 patients subjected to early operation might have been greater with delay, since several had gangrenous gallbladders. As nearly as could be determined, there were no liver deaths such as reported by Heyd.⁴

A summary of the protocol on cases in which death occurred is as follows:

Early operations

1. A.S., 64, white male. Acute and chronic cholecystitis with cholelithiasis. No common duct exploration. *Cause of death*—massive pulmonary embolus, residual common duct stone.

2. W.M., 70, white male. Acute and chronic cholecystitis, abscess of gallbladder wall. Common duct explored. *Cause of death*—acute pancreatitis, acute inflammation of the common duct, lower nephron nephrosis, aspiration pneumonia.

3. L.P., 71, white female. Acute and chronic cholecystitis with stones. *Cause of death*—sudden and unknown. Although permission for necropsy was not obtained, the clinical impression was one of myocardial infarct or massive pulmonary embolus.

Elective operations

4. E.R., 67, Negro female. Acute cholecystitis with stones. Common duct explored. *Cause of death*—cerebral vascular accident, duodenal fistula, phlebothrombosis, myocardial ischemia.

5. W.M., 72, white male. Chronic cholecystitis with stones. Common duct explored. *Cause of death*—pulmonary embolus.

6. T.C., 69, white male. Chronic cholecystitis with stones. No common duct exploration. *Cause of death*—myocardial failure, lower nephron nephrosis.

MORTALITY FOLLOWING CHOLECYSTECTOMY (Non-malignant cases only)			
Procedure	No. of Cases	Mortality	Percentage
Early operations	51	3	5.9
Elective operations	156	3	1.9
All patients	207	6	2.9
Without common duct exploration	188	3	1.6
Early operations	46	2	4.3
Elective operations	142	1	0.7
With common duct exploration	19	3	15.8
(2 patients had 2 procedures each)			

Table IV

In most reports dealing with similar series of patients, the mortality rate increases sharply above the age of 50.^{5 6 7} In this series, no deaths occurred in patients under 64 years of age, who comprised 75 per cent of the total number, and the average age of the six fatalities was 68.8 years.

Mortality data on all patients according to procedure and with reference to common duct exploration is given in Table IV.

Morbidity

A majority of the patients, even when recovery was uncomplicated, experienced some degree of post-cholecystectomy fever (Table V).

POST-OPERATIVE FEVER		
Degree	Elective Patients (%)	Early operation Patients (%)
None	13.2	7.8
Mild to Moderate	74.6	74.5
99.6 to 101 F.		
Severe	12.2	17.7
101 to 103 F.		

Table V

POST-OPERATIVE COMPLICATIONS			
In 207 Non-Malignant Cases of Gallbladder Disease			
Location and Type	Occurrence*		
	In 22 of the 156 Elective Cases	In 19 of the 51 Early Cases	
Local	18	11	
1) wound infection	14	6	
2) bile drainage	3	3	
3) subphrenic abscess	1	2	
4) hemorrhage	0	0	
Pulmonary	5	5	
1) atelectasis	4	3	
2) pulmonary embolus	1	1	
3) pneumonia	0	1	
Cardiovascular	5	1	
1) thrombophlebitis	3	1	
2) cerebral vascular accident	1	0	
3) myocardial ischemia (or infarct)	1	0	
Genito-urinary	5	3	
1) uremia	0	1	
2) pyelonephritis	4	0	
3) lower nephron nephrosis	1	1	
4) prostatic obstruction	0	1	
Visceral	3	3	
1) intestinal fistula	1	0	
2) jaundice	1	0	
3) cholangitis	1	1	
4) pancreatitis	0	2	

*Several patients had multiple complications.

Table VI

Postoperative complications, in many instances multiple, occurred in 14 per cent of the elective group and in 37 per cent of the group operated upon within 24 hours of admission (Table VI). The relatively high incidence of wound infections, compared to those usually encountered on the surgical service, led to a review of the particular instances, and it was found that 85 per cent of the patients with infected cholecystectomy wounds also had diabetes. There was no evidence of common duct stricture or any other type of ductal damage in this series.

A general estimation of disability may be determined from the length of postoperative hospitalization and from the number of return visits made to the outpatient clinics following discharge. The patients subjected to early operation had an average hospital stay of 9.5 days as compared to 8.2 days for those in the elective group. All patients were operated upon at least one year prior to the preparation of this report and have been seen in the interim. The 51 patients with early operations made an average of 3.2 return visits to the clinic, whereas members of the elective group averaged 3.6 visits. A definite post-cholecystectomy syndrome was experienced by six patients, five of whom had elective operations. This was in ratio of 3.2 per cent for the elective patients to 1.9 per cent for those with early operations.

Discussion

A review of the literature reveals that over-all mortality has been the only consistent item in statistics dealing with series of cholecystectomies. This single factor is deemed inadequate for evaluating the merits of early operation for, as was true in this series, the death rate might have been as great with conservative treatment. Our mortality rate of 2.9 per cent compares favorably with those given in other reports (1.1 to 10 per cent for simple cholecystectomy),^{4-6, 8-11} particularly since there were no private patients in this series. Many of the patients, because of their socio-economic status, suffered from debilitation and poor nutrition and cannot justifiably be compared with private clinical patients.⁴

The described criteria for early operative intervention during the acute phase of gallbladder disease are believed to be both conservative and critical. Patients with severe manifestations, but otherwise in excellent health, are spared prolonged hospitalization and repeated attacks of biliary colic. Even with careful evaluation, however, the mortality and incidence of postoperative complications is greater among patients submitted to early cholecystectomy than in those with elective procedures.

Disability is necessarily prolonged in patients in whom the acute manifestations are allowed to subside because the initial period of conservative treatment is followed by re-admission to the hospital for

Incidence of Diabetes

ELEVEN PER CENT of children born to diabetic mothers develop the disease, which is 225 times oftener than diabetes occurs in the general population. If both parents are diabetics or potentially so, all the offspring will be predisposed to this disorder. On the other hand, if both parents are non-diabetic but carry the trait which they received from their parents, then one-fourth of the children will be diabetic.

An inherited tendency is not the only cause of diabetes, for obesity has a lot to do with it. It has been estimated that 80 per cent of all new diabetics are definitely overweight at the beginning of their disease. This applies to adult diabetics, and more especially to the older diabetic.

In 1914 the average age of diabetics at death was 44½ years while in 1951 the average age was nearly 65.

An Evaluation of Early Operation in Acute Inflammation of the Gall Bladder—(con't.)

elective cholecystectomy. It has been the preference of members of this surgical service to operate upon these patients approximately four to six weeks after acute symptoms have subsided. When early intervention is indicated, it has been found best to operate no later than five to seven days after the onset of the acute attack, and preferably within four days. The most unsatisfactory period has been found to be three weeks after subsidence of acute manifestations, for at this time the procedure has proved most difficult technically.

Indications for exploration of the common duct are conservative and the number for this series is, therefore, small (9.1 per cent). The mortality following common duct explorations is admittedly high, but expectedly so since the patients on whom it was done were frequently the most ill in the group.

The absence of evidence of trauma to biliary duct structures is a measure of the importance of technic in surgery of the gallbladder and of the surgeon's awareness of his responsibility in avoiding such injury. No insurmountable difficulties were mentioned either in the operative notes or in the discussions of this phase of the problem to indicate that cholecystectomy for acute disease was technically more difficult than for chronic disease or that it carried a greater risk of biliary duct damage.

The major difficulties encountered were those common to all geriatric surgery. It is evident that every effort should be made to allow acute manifestations in patients over 60 years of age to subside and to perform elective cholecystectomy under ideal conditions and after thorough preparation. Early recognition and treatment of pulmonary, cardiovascular, and renal complications can further reduce mortality and morbidity.

Although immediate operation is frequently indicated during the acute phase of many inflammatory

diseases, such as appendicitis, it is believed that results justify a middle course whenever possible in the treatment of cholecystitis, either acute or chronic.

Summary

1. The results in 51 early and 158 elective operations for inflammatory disease of the gallbladder and biliary tract have been studied and compared. Factors considered include mortality, morbidity, complications, surgical trauma, postoperative sequelae, length of hospitalization, and disability.

2. *Early operation* is the choice in acute cases (a) if there is evidence that gangrene or perforation are present or impending, or (b) if the patient is in otherwise excellent health.

3. *Elective operation*, preceded when necessary by antibiotic and supportive therapy until severe manifestations have subsided, is preferable in the remaining acute and chronic cases.

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Evaluation of Bonamine* in Nausea and Vomiting of Pregnancy

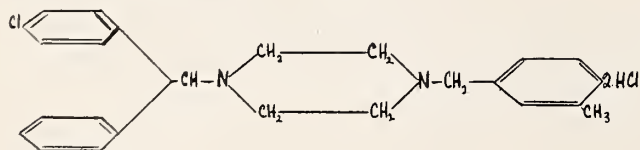
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THE ENIGMATIC PROBLEM of nausea and vomiting of pregnancy has long presented a difficult therapeutic problem to those physicians engaged in obstetrical practice. This syndrome, which occurs in approximately 75 per cent of all pregnancies in varying degrees of severity, has been considered etiologically to have nutritional, endocrine, and psychogenic bases. Yet treatment directed along one or more of these lines (frequent high carbohydrate feedings, pyridoxine, hormones, superficial and deep psychotherapy), although effective in a certain percentage of patients, has never proved successful in the majority of cases. Furthermore, when such measures have failed the syndrome has progressed in some instances to the more severe condition, hyperemesis gravidarum, which may be attended by serious complications, such as hemorrhagic retinitis and fatty degeneration of the liver, requiring hospitalization with strict bed rest and parenteral alimentation.

The purpose of this paper is to present the background and results of therapy in a series of 100 gravid patients treated with a new compound, Bonamine,^{1 2 3} which would seem to possess the ability to effectively and rapidly control nausea and vomiting of pregnancy in almost all cases with a minimum of undesirable side effects. As will be noted, this new medication would appear to offer marked advantages over many previously employed remedies.

Pharmacology

Bonamine, a recently discovered antihistaminic drug, is designated chemically as p-chlorobenzhydrylm-methylbenzylpiperazine dihydrochloride and has the following structural formula:



It may be seen from examination of this formula that Bonamine differs from related antihistamines by having three, instead of two, benzylic rings in its structure. This difference may account for Bonamine's more potent and prolonged antinauseant and antiemetic properties.

*Bonamine (brand of meclizine hydrochloride) was kindly supplied by Dr. M. Carlozzi, Medical Dept., Chas. Pfizer and Co., Inc., Brooklyn, N. Y.

As to its site of action, Bonamine is believed to exert its favorable therapeutic effects both by depressing the labyrinthine mechanisms (which accounts for its efficacy in motion sickness) and by inhibiting the vomiting center in the medulla. Further, this new agent has a duration of action of up to 24 hours following a 25 to 50 mg. oral dose which is of significant aid when treating nausea and vomiting of pregnancy since it obviates repetitive dosing, once or twice a day usually being sufficient.^{4 5 6}

Laboratory studies on the acute and chronic toxicity of this drug have revealed no untoward effects. LD₅₀ determinations reveal Bonamine to be less toxic than other currently-used antihistaminics including dimenhydrinate. Again, administration of doses in excess of those used in humans for a period of over six months gave no evidence of any morbid changes. Bonamine, interestingly, was shown to have far greater antihistaminic activity, as measured in guinea pigs by duration of protection against intravenous or nebulized histamine, than other related drugs.⁷

Clinical evidence attesting to the safety of Bonamine in both the mother and fetus has been reported by Bass⁸ and McKenna.⁹ These investigators found no indication of any deleterious actions to either mother or child after their evaluations of this compound in 226 patients.

Clinical Material

In this test series, 100 patients in the first trimester of gestation were treated with Bonamine. The cases were not screened as to age, race, duration of symptoms, or number of pregnancies. They were selected, however, by excluding any patients who had hyperemesis gravidarum or who were borderline to this condition, being unable to retain anything at all by mouth.

Bonamine was administered routinely on the following dosage schedule: one 25 mg. tablet at bedtime and another 25 mg. tablet on awakening. This latter dose was ingested prior to arising in every case. Supplementary hourly feedings of dry solid foods, such as cookies, crackers, and toast were also advised.

Those patients suffering from such severe symptomatology as to be unable to tolerate anything by

mouth were first treated by parenteral administration of glucose and saline, pyridoxine (vitamin B₆), and sedation. When they had recovered sufficiently to be able to handle oral medication, these patients were placed on Bonamine in the aforementioned dosage regimen.

Aside from Bonamine, no other drugs were used to treat these patients. Again no vitamin preparations were given. This was done in order to avoid possible confusion in interpreting the therapeutic findings.

Results of Therapy

Of the 100 patients treated with Bonamine, the symptoms of both nausea and vomiting were completely controlled in 64 (excellent), partially helped—vomiting stopped but occasional episodes of mild nausea persisted—in 24 (good); and not helped at all in 12 (poor). Thus, 88 of the patients were either completely relieved of both nausea and vomiting or were rendered free of vomiting but had occasional mild attacks of nausea. These results are similar to those obtained with Bonamine therapy by Bass⁸ who reported that 164 (90 per cent) of 182 patients became completely asymptomatic, and McKenna⁹ who found that 40 (91 per cent) of 44 cases were totally relieved of both nausea and vomiting.

In most of these instances, the therapeutic actions of Bonamine were evident within several hours after the first dose and were maintained throughout the entire period of the drug's administration. This latter fact would seem to indicate that patients do not acquire tolerance to the beneficial actions of this compound and, therefore, no "escape" phenomenon occurs.

Further, the incidence of relief obtained from Bonamine in this and other studies^{8,9} is far superior to that reported following the use of other antihistaminic drugs. Cartwright in a study of 89 women suffering from nausea and vomiting of pregnancy found that only 22 (24.7 per cent) of their patients experienced complete relief from dimenhydrinate, while in 26 cases (29.2 per cent) this drug proved totally ineffective.¹⁰ Again, Carliner, Radman, and Gay were able to render asymptomatic only 31 (72.1 per cent) patients out of a series of 43 using dimenhydrinate.¹¹

One clinical impression gained by the authors during this study was this: it seemed that the sooner Bonamine was started after the onset of the symptoms the more efficacious it was. Although realizing that it is difficult to draw rigid conclusions from such a small series of cases, it is felt that the earlier Bonamine can be prescribed the less chance there will be for failure. In 10 of the 12 patients who received no benefit from this drug, the medication was not started until during the third month of pregnancy, where-

as had treatment been begun sooner these 10 women might have been wholly or partially relieved.

Side Effects

Only two side effects were noted in this group of 100 cases: mild drowsiness and transient light-headedness (not vertigo). Ten patients complained of slight drowsiness, and two of these same 10 patients stated that they were "light-headed." In none of these women were these symptoms of sufficient severity to necessitate withdrawal of medication, nor were they of a degree to incapacitate these patients' performance of their everyday activities. There were no occurrences of severe sedation, dryness of the mouth, blurred vision, inability to concentrate, tachycardia, gastrointestinal complaints, or muscular incoordination as sometimes follow other antihistamines¹² or chlorpromazine.¹³ Moreover, chlorpromazine, although widely prescribed for its antiemetic properties, can produce jaundice and liver damage following prolonged administration. One fatality due to agranulocytosis has recently been reported which would seem to indicate that this compound may be unsafe to give to pregnant women.¹⁴

Alteration of dosage from the schedule used in this series (25 mg. h.s. and 25 mg. before arising) to 25 to 50 mg. h.s. alone or with a supplemental dose of 12.5 mg. (half a tablet) at about 10 a.m. will often eliminate even the mild drowsiness if it does occur.

Summary and Conclusions

Bonamine, a recently discovered antihistaminic compound with marked antinauseant and antiemetic properties, was given to 100 pregnant women suffering from nausea and vomiting of pregnancy with excellent results in 64 (no nausea and vomiting), good results in 24 (no vomiting but occasional episodes of mild nausea), and poor results in 12 patients. This remarkable new drug because of its prolonged duration of action (up to 24 hours) is ideally suited to keep patients symptom free throughout the night and during the difficult morning hours. Although in this series a 25 mg. dose was given at bedtime and upon arising, frequently patients can be maintained symptom free by a single 25 to 50 mg. dose taken on retiring.

It is the opinion of the authors that the earlier in the first trimester of gestation Bonamine therapy is instituted the greater will be the number of patients who are completely relieved. This belief is supported by the fact that 10 out of the 12 failures were not started on treatment until the third month of their pregnancy.

Bonamine is a drug which is safe and nontoxic to both the mother and fetus and which is attended by a minimum of undesirable side effects. In this study there were 10 patients who complained of mild

drowsiness, two of whom had the additional complaint of "light-headedness" (not vertigo). There were no adverse reactions, such as blurring of vision, dryness of the mouth, gastrointestinal symptoms, or muscular twitching which sometimes are seen following the use of drugs like chlorpromazine or dimenhydrinate.

From the results of this study, it is concluded that Bonamine is a highly efficacious drug which will provide symptomatic control in the majority of patients suffering from nausea and vomiting of pregnancy.

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Fluoridation in Georgia

ALMOST 500,000 GEORGIAN'S now are drinking water that has been fluoridated to prevent tooth decay.

The recent addition of Augusta brought to 35 the number of communities in the state that are adding controlled amounts of fluoride to their public water supplies. Several other communities will begin the process soon. Throughout the nation, fluoridation programs are serving more than 21,000,000 people.

Apathy of citizens and hesitancy of local government officials—rather legal objections—apparently are posing the greatest obstacles to immediate nationwide adoption of fluoridation of public water supplies. However, the program continues to spread.

Augusta city officials began serious consideration of a fluoridation program less than two years ago, after figures from extensive nationwide tests indicated as much as 60 per cent decay reduction in the teeth of children who drank fluoridated water during the first eight years of life. In many instances, older children also were found to have less decay in areas where the program was in effect.

Atlanta, in contrast, has been considering the measure almost five years but has taken no action, in spite of recommendations by the American Medical Association, American Dental Association, Georgia Dental Association, State Board of Health, State Health Department, and many other organizations.

Dr. John E. Chrietberg, director of Dental Health Service for the State Health Department, said that

the legality of fluoridation of public water supplies has been tested and upheld in California, Oklahoma, Wisconsin, Ohio, Louisiana, and Washington.

The U. S. Supreme Court refused to review California, Louisiana, and Oklahoma state court decisions upholding the right of municipalities in those states to fluoridate their public water, sustaining the lower court rulings, in effect.

The Oklahoma State Supreme Court had upheld the right of Tulsa to fluoridate, stating that "there can be no distinction between (fluoridation) and compulsory vaccination or inoculation," in its opinion.

A Wisconsin court judge had upheld the fluoridation of public water supplies in Milwaukee, stating that "the health measure is not a violation of religious freedom and is not the practice of medicine, dentistry, or pharmacy by the city." He pointed out that the purpose of fluoridation is "to promote and protect the public health."

The fluoridation program in Chicago, Illinois, began this fall after Governor William G. Stratton had vetoed a bill which would have authorized a referendum on fluoridation. In his veto of the anti-fluoridation bill, Governor Stratton noted that "a referendum cannot establish or destroy a scientific fact."

A similar bill, sponsored by a religious group and chiropractors, was defeated by a New Hampshire legislature.

The Treatment of Lung Abscess

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IN ALL THE ANNALS of medical therapeutics, one cannot find a story to parallel the progress made in the treatment of pulmonary abscesses. A scant 18 years ago saw pulmonary abscesses carrying a mortality of 34 per cent¹ and a morbidity even higher than that. If a patient were fortunate enough to survive the acute phase of his abscess, in approximately 50 per cent of the cases, he would carry a chronic draining broncho-pleural cutaneous fistula, bronchiectasis, or recurrent pulmonary hemorrhage, which would eventually cause his death. Recently Waterman and Dorm² showed that the mortality rate in over 200 cases was less than 10 per cent. Even more important is the lowering of the morbidity following an acute pulmonary abscess. With the use of antibiotics, conservative drainage procedures, and surgery, one is able to handle satisfactorily 80 per cent of the acute lung abscesses³. The major contributing factor this miraculous change in a very serious disease is the antibiotics that are now available for the treatment of acute pulmonary infections. In addition to this, the improved techniques for thoracic surgery have lowered the mortality and morbidity of those cases not responding to ordinary therapeutic measures.

In spite of this very optimistic picture, we feel that lung abscess still must be considered a serious disease. This report deals with approximately 70 cases of lung abscess seen in a group of patients who present a very difficult therapeutic approach. These cases were taken from the city hospital and from the Veterans Administration Hospital. We have to consider this to be a group of indigent patients. All cases of a private status are purposely omitted from this report. Granting that we are dealing with protoplasm that is difficult to handle, as well as a group of individuals who in some cases are reluctant to take medical advice, the disease process is still a serious problem. In this group of 70 cases, there is a mortality rate of approximately 11 per cent, which is well above the mortality rate reported in the handling of private cases. We agree with Waterman and Dorm² in emphasizing that lung abscess is a surgical disease from the onset and should be considered as

such. In reviewing this group of cases, we were surprised to see the delay between the onset of disease and hospital treatment. The average time between onset of symptoms and admission to the hospital was 30 days. Many patients had inadequate antibiotics and totally inadequate therapy for weeks before the time that the true nature of the pathology was discovered.

In considering the etiology of lung abscess, there are five factors that we would like to discuss. They are: (1) Disturbed bronchial physiology, (2) Infection, (3) Ischemia, (4) Embolism, (5) Obstruction, (6) Trauma.

1. Disturbed Bronchial Physiology—The loss of the cough reflex is the major factor in the disturbed physiology leading to lung abscess. This loss aids in the aspiration of foreign material into the bronchial tree. Dealing with an indigent group of people we found that alcoholism was a very common factor. Alcohol, as well as anesthesia, can produce a stuporous condition, in which the patient loses, completely, his cough reflex and his ability to prevent aspiration of vomitus and other foreign material. It is known that the action of the cilia, as well as the cough reflex, has a great deal to do with the movement of foreign material from the tracheal tree. Alcohol, anesthesia, or periods of unconsciousness each as occur in epilepsy, are prone to destroy these two actions.

2. Infection—Pulmonary suppuration is still the most common cause of lung abscess. It is in this group of patients that pulmonary suppuration is prevalent and poorly treated. Preexisting bronchiectasis is still a factor in the production of lung abscess. Many of this group showed a very dirty mouth with many carious teeth. This is still considered by some to be the most important single etiologic agent. It is interesting that only one case of lung abscess following tooth extraction was present in this group.

3. Ischemia—Pulmonary infarction may lead to abscess. Pulmonary emboli, following thrombophlebitis, producing ischemia to a section of the lung and infarct may lend itself quite readily to the production of lung abscess.

4. Embolism—Numerous episodes of embolic phenomena from areas of infection have been noted to produce multiple pulmonary abscesses. Multiple

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pulmonary abscess in subacute bacterial endocarditis is not uncommon.

5. Obstruction—This is a very common and important cause of lung abscess. Any abscess must be considered as a possible malignant process until proven otherwise. Obstruction such as bronchial stenosis, tracheal stenosis, or laryngeal stenosis, may contribute to the production of lung abscess. The aspiration of foreign material with actual obstruction, such as foreign bodies in children, commonly produce lung abscess.

6. Trauma—In injuries to the chest one may see spicules of ribs driven into the lung substance. This may lead to abscess. Occasionally gunshot wounds or other trauma may lead to abscess.

Most people feel that aspiration of infected material is one of the most common causes of lung abscess. Operations on the mouth and nasal passage such as tonsillectomy, etc., are high on the list of operative causes. Maersch and Olsen⁴ in review of 264 cases of lung abscess found that 128 followed surgical procedures. The use of endotracheal aspiration and endotracheal intubation has lowered this source of contamination.

Adequate history of the patient is essential—with emphasis on details regarding alcoholism, periods of unconsciousness, or any recent surgical procedure followed by acute infection, cough, production of purulent secretion, and hemoptysis. Pain in the chest is quite often present with lung abscess. Physical

findings may be numerous over the lobe involved, or as in many cases, may be totally absent. Presence of a very dirty mouth leads one to feel that lung abscess may be present. Laboratory examination of the sputum is important. The sputum is usually foul, green in color and layers deep. Cultures of the sputum should be made to rule out the presence of tuberculosis and to try to delineate the active organisms with sensitivity studies to find the more adequate chemotherapy agent. X-ray is extremely important in the early stages. It may show only a massive infiltrated area suggestive of lobar or bronchial pneumonia, which later excavates with or without the presence of a fluid level. The laminogram may be extremely helpful in picking up multiple small cavities that are not seen on plain x-ray. Both Posterior-Anterior and Lateral views are essential to outline the segment of disease, so that an adequate approach may be made. As stated above, bronchoscopy should be done in every case, not only for drainage purposes, but to be certain that endobronchial obstructive phenomena are not present. One cannot always rule out neoplasm. Several cavitory neoplastic lesions have been encountered. In each case, a "typical thumb sign" was present. This is shown in Figure 1. If this sign be present, neoplasm must be considered as a primary diagnosis.

The treatment of lung abscess is often a long and tedious process. In our group of 70 cases, the average hospitalization was 40 days. The longest period was 88 days and the shortest was 15 days. In this group of 70 cases, we encountered 59 males and 11 females. However, considering the city hospital where there is an equal number of male and female patients, there were approximately 35 males and 10 females, giving a proportion of about 3½ to one in favor of the males. There were 35 colored and 35 white patients. The youngest patient was two months of age, and the oldest was 68 years. Symptoms of cough, production, dyspnea, pain, and hemoptysis were quite common in all of these cases. There were only four cases out of the 70 with hemoptysis, the major symptom, and it was massive in all four of these cases. There were significant physical findings present in only about half of the cases. The white blood count was elevated in 45 cases. It was decreased in two and essentially within normal limits in 23. Sputum cultures were not done on all patients. On those cultured numerous organisms were encountered, and only on rare occasions did a pure culture of any particular organism show up. Alpha streptococcus was by far the most predominant organism found. Klebsiella and hemolytic staph aureus were also common findings.

In 1946, a rather definite program was set up in regard to the care of patients with lung abscess. Al-

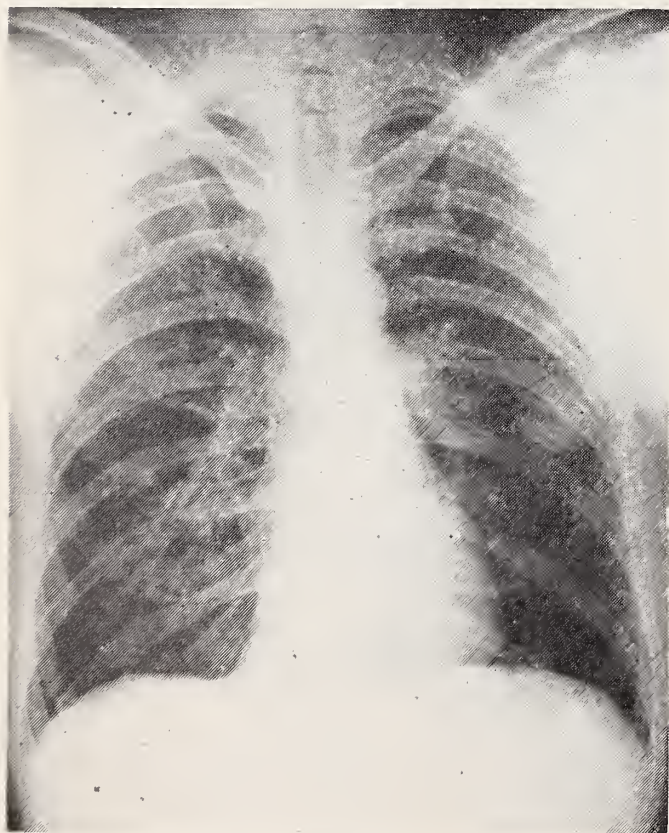


Figure 1

Cavitory lesion showing the so-called "thumb sign." Proven case of bronchogenic carcinoma.

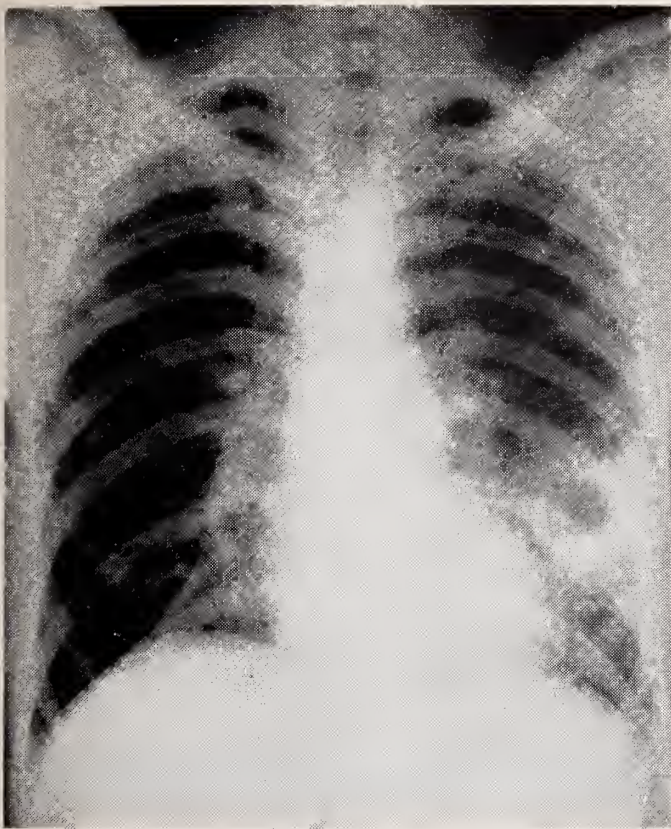


Figure 2A
Acute stage of suppurative lung abscess.

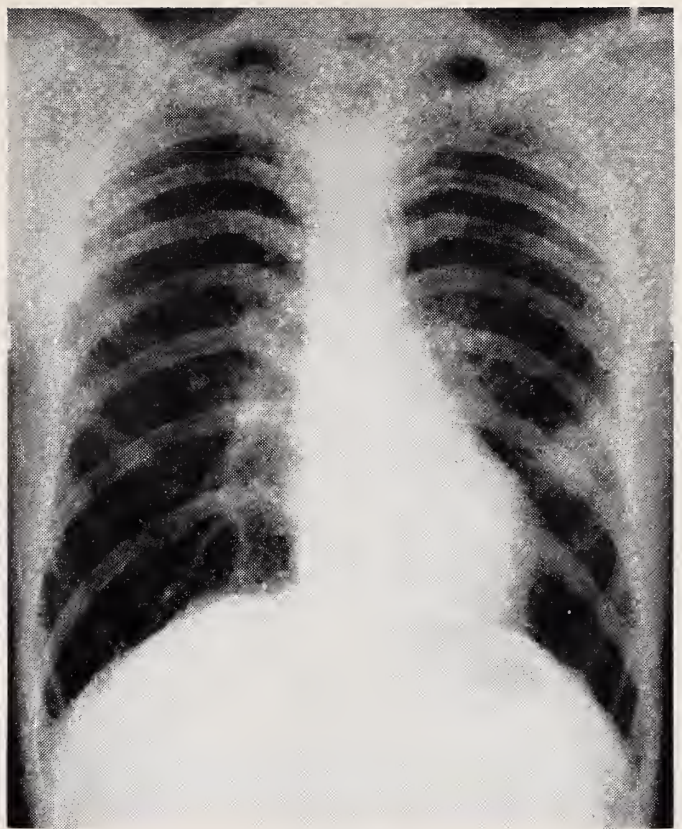


Figure 2B
This shows satisfactory healing of an inflammatory process, following repeated endoscopy.

though this has varied in some degree as time has gone on, the basic principle has not changed. This has been the use of antibiotics plus bronchoscopic drainage. We feel very strongly that bronchoscopy is of prime importance in the treatment of lung abscess. Antibiotics, for the main part, included penicillin as the basic stand-by with a change to the broader spectrum if results were not suitable with it. If sensitivity studies of the major organism showed that other drugs had much better sensitivity, then they were used. As most of the patients were treated in the city hospital, the least expensive therapeutic agent that could be used by them was penicillin. In most cases, this has worked out very well. Aerosol was used in only three cases of this group, and we have waxed and waned in regard to the feeling of the necessity for Aerosol. If used in massive doses in conjunction with parenteral antibiotics, we feel that it does have some definite benefit. On an open ward in the city hospital, it is extremely difficult and even somewhat hazardous to use Aerosol medication in conjunction with oxygen.

An attempt at culture was made in most of these patients, although significant organisms were found in only a small percentage. Multiple organisms were found in almost all cases cultured. Postural drainage was instituted on each case and an attempt was made to have the patient in position for optimal drainage of the segment involved.

Of prime importance in establishing drainage in lung abscess is the use of the bronchoscope. Poppe,⁵ Waterman and Dorm,² and others,⁶ have emphasized this fact. All of the cases except five received bronchoscopy, and in 42 of these cases more than one bronchoscopic examination was done. We would like to emphasize the fact that repeated endoscopic drainage is important unless the abscess is showing rapid and progressive healing. Certainly every abscess should be bronchoscoped sometime during the course of the disease to try to establish better drainage, to help rule out the presence of neoplasm, and to be certain that a foreign body or bronchial stenosis is not the etiological agent. At bronchoscopy, an attempt is made to enter the abscessed cavity with the bronchoscopic tip; however, this is not always practical or feasible, and shrinking agents are applied directly to the segment of disease with an attempt to shrink the bronchial mucosa at this level to allow for better drainage. It is not uncommon for the bronchoscopist to find very little at the time of endoscopy, and then over a period of the next several days the patient will cough up large quantities of purulent secretions, and on further check of the x-ray, the cavity is seen to be open and drainage established, with healing begun. (Figure 2) It is important to remember that the timing of the initial endoscopy is of extreme importance. A patient who enters the hospital acutely ill with high temperature and a ful-

COMPLICATIONS OF LUNG ABSCESS

Hemoptysis, massive	4
Broncho-Pleural Fistula	5
Empyema	2
Pyopneumothorax	1
Pneumothorax	1
Bronchiectasis	2
Overwhelming Infection	4

Chart 1

RESULTS OF TREATMENT OF 70 CASES OF LUNG ABSCESS

	No.	Per cent
Well, with no evidence of residual disease	50	75
Clinically well, but X-ray evidence of persistent cavity	5	5.5
Persistent broncho-pleural fistula	2	3
Bronchiectasis residual	1	1.5
Deaths	9	11
Unknown	3	4

Chart 2

SURGICAL PROCEDURE EXCLUDING ENDOSCOPY AND RESULTS

	No.	Results
Lobectomy	4	1 Death 3 Excellent
Pneumonectomy	2	2 Broncho-Pleural Fistulae
Thoracoplasty	2	2 For Broncho-Pleural Fis- tula, one persists
Thoracotomy Drainage	7	7 Good
Tracheotomy	2	2 Good
External Drainage	1	1 Fair, fistula persists
	18	

Chart 3

CAUSES OF DEATH

Overwhelming Infection	4
Cardiac Arrest During Bronchoscopy*	1
Massive Hemorrhage	2
S. B. E.	1
Post Lobectomy	1
Unknown	1

*Patient received epinephrin instead of ephedrine.

Chart 4

minating abscess is no candidate for immediate bronchoscopy. A cooling off period should be allowed. Antibiotics should be given to quiet the abscess for awhile before traumatic procedures are done. Usually a period of two to five days is allowed before the first endoscopic procedure is done, unless there is some other urgent indication for same. In only five cases out of 70 was endoscopic drainage omitted. Only one of this group showed satisfactory improvement and this was after 39 days of attempted diagnosis of underlying pathology. More than one bronchoscopy was done on 42 cases. On 65 cases, a total of 156 bronchoscopic procedures was done.

The x-rays play an important part in both the diagnosis and the follow-up of lung abscess cases. It is the only means of observing the progress of a cavity. Any persistent cavitation on x-ray should be watched with care, and if the symptoms continue, as most of them do, the patient should be considered a candidate for resection. Also, any patient who shows evidence of continued infection with cough, hemoptysis, or production of pus should have bronchograms done. Some patients will be left with bronchiectatic changes in addition to a cavity.

The results of these cases are tabulated in Chart 2, and we can see what was considered a satisfactory result in 50 cases, or 75 per cent. There were nine deaths in this series. This gives an overall mortality of 11 per cent. Eight cases are pending for further care. Three of the group have unknown results.

Apparently overwhelming infection was the cause of death in four of the patients in this group. One case of subacute bacterial endocarditis and two cases of massive pulmonary hemorrhage accounted for three deaths. The one death following pulmonary resection was thought to be due to a massive infection by an organism that was totally resistant to all forms of chemotherapy. (Chart 4) One death occurred during bronchoscopy from an overdose of epinephrin that was given by mistake.

Surgery in lung abscess is divided into two phases. One is during the acute process and the other is for eradication of chronic lung disease. During the acute phase, some people have recommended aspiration of the abscessed cavity with the injection of antibiotics directly into it. We feel that this is a dangerous procedure and would certainly fear spread of infection.

In cases with considerable purulent secretions, associated with an inability to cough, and massive pulmonary infection, tracheotomy may be a lifesaving procedure. The immediate treatment of complications, such as empyema and broncho-pleural fistula, is extremely important in the presence of lung abscess. Drainage of the empyema should be early and should be immediate when a broncho-pleural fistula has been proven. The use of closed thoracotomy with revision at a later date, was employed in all of our cases of empyema and broncho-pleural fistula.

We feel that external drainage of the lung abscess is almost never necessary. In this group of 70 cases,

only one case has had indications for external drainage. This was because of rather severe associated cardiovascular disease. In the extremely ill patient, with a large abscess that is not responding to treatment, one may consider external drainage. (Figure 3) Resection should be reserved for that group of cases developing into chronic lung abscess or bronchiectasis or for persistent pleural fistula. There has been some difference of opinion in regard to the time lapse necessary to consider a lung abscess chronic. It is usually thought that if after two months of medical treatment, including bronchoscopy, the abscess has not healed, that it is not going to heal. However, in this group there were several patients, known to have had lung abscess for two to three months before admission to the hospital, whose abscesses healed very rapidly with treatment. Certainly one should try to obtain a satisfactory result with the use of antibiotics, expectorants, postural drainage, and endoscopy for an adequate period of time before resorting to resection. We would like to make a plea here for the conservation of lung tissue. Resection wherever feasible should include only the segment involved. However, as all of you know, this is the most difficult type of resectional surgery. Often the inflammatory process does not limit itself to the segmental plane. However, if possible, segmental resection is the surgery of choice.

One of the complications of resection is the persistent broncho-pleural fistula. We believe that one of the major causes of broncho-pleural fistula is the presence of an organism that is totally resistant to antibiotics. If possible, the organism responsible for the predominant organism should be studied very carefully for its sensitivity, and an attempt should be made to eradicate it as nearly as possible before surgery.

Results of surgical treatment in lung abscess are tabulated in Chart 3.

Summary

Although great strides have been made in the treatment of lung abscess, we feel that it is still a very serious pulmonary disease. We should like to emphasize that it is basically a surgical disease from the onset, and that an attempt should be made to obtain more rapid and early treatment of the acute inflammatory episode occurring previous to the actual formation of an abscess. We feel that the average time of 30 days from onset of symptoms to admission to the hospital is far too long and that the early referral of the patient is greatly needed to facilitate the proper treatment of the disease. Proper antibiotics are extremely important in controlling the inflammatory process of the disease. The use of bronchoscopy for endoscopic drainage of the abscess is

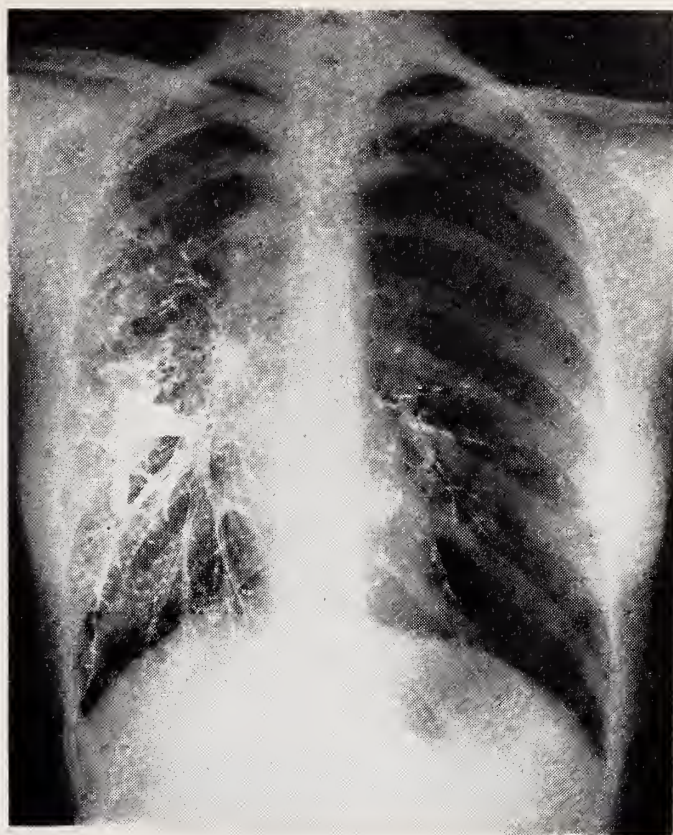


Figure 3

Bronchogram on a chronic lung abscess showing cavitation and severe ectasia.

of prime importance. Repeated endoscopy is often necessary and should be done until complete healing is obtained. If, after an adequate regimen of two months or more is carried out, infection is still present, then one must consider resection of the abscess as it is in a chronic stage. The treatment of complications, such as broncho-pleural fistula, or empyema, or pneumothorax, consists of immediate drainage; and for the persistence of broncho-pleural fistula or bronchiectasis, one must consider resectional surgery. The use of the bronchogram to completely delineate the lobe so that areas of bronchiectasis will not be left in place following resection, must be carried out. (Figure 3) We believe that with more judicious following of the patient and earlier referral, with more intensive chemotherapy and more vigorous endoscopy, one may be able to lower the mortality and morbidity rate even further than it is at the present time.

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Peridontoclasia and Osteoporosis Associated with Endocrine Disorders

J. K. FANCHER, M.D., S. P. VAIL, D.D.S., and T. W. ETHERIDGE, D.D.S., Atlanta, Ga.

THE RELATIONSHIP of peridontoclasia with thyroid deficiency and other glandular disorders has been noted by dentists in recent years.^{1 2} Albright³ was one of the first to show the relationship between osteoporosis and estrin deficiency. The combination of peridontoclasia, osteoporosis, and endocrine disturbance so far has not been reported. Since Dr. Vail first suspected this triad, we suggest it might be called Vail's Syndrome.

A preliminary report is presented on a series of 20 patients who have been studied and treated during the past 18 months, with the diagnosis of peridontoclasia, osteoporosis, and endocrine disturbance.

Peridontoclasia is a destruction of bone around the teeth. Dentists have battled with this problem for years, and so far have been unable to interest the medical profession in this condition. Osteoporosis is a term which has been loosely used to indicate any increased porosity or lessened calcification of the bone. The dictionary definition (Gould) is: "an enlargement of the spaces of bone, whereby a porous appearance is produced." Follis⁴ in an excellent discussion of the subject, classifies osteoporosis into six classes: (1) developmental disturbances (such as osteogenesis imperfecta); (2) nutritional disturbances (vitamin deficiencies); (3) endocrine disturbances (pituitary, gonads, parathyroids); (4) circulatory disturbances (immobilization); (5) presence of adventitious cells (leukemia); (6) undetermined. He concludes: "it would appear that there are numerous facets to the osteoporosis problem which have yet to be elucidated. The role of constitutional or genetic factors and of many other as yet undisclosed causes remains for the future to clarify." It is the opinion of Rectman and Yarrow⁵ that all the factors in osteoporosis are as yet not fully known and they suggest the "X" factor to be added.

Differential diagnosis:

In osteoporosis, the process is one of de-ossification or loss of bone substance. The total serum calcium level is normal.

In hyperparathyroidism, high blood calcium decreased phosphorus, elevated alkaline phosphatase, cystic bone changes often first found in the mandible.

Generalized Paget's Disease, (ostitis deformans), high alkaline phosphatase, skull frequently affected both by bone destruction and bone production.

Osteomalacia, similar to adult rickets, renal abnormalities, calcium deficiency, serum calcium phosphorus, alkaline phosphatase are abnormal.

Multiple myeloma, symptoms of backache, frequent bone ache, compression fractures of spine, serum globulin high, protein high, normal a/g ratio, plasma cells on differential smear, Bence-Jones protein in urine.

Scurvy. Lack of ascorbic acid (vitamin C), deficient formation of bone matrix, causing osteoporosis.

Osteoporosis has been reported as resulting from a variety of causes such as senility,⁶ potassium thiocyanate for hypertension,⁷ diet deficient in calcium and phosphorus,⁸ hyperthyroidism,⁹ vitamin A deficiency with dysthyroidism,¹⁰ vitamin D deficiency,¹¹ hyperparathyroidism,¹² malignancy, chronic diarrhea and hyperplasia of parathyroids,¹³ pituitary basophilism, adrenocortical syndrome,¹⁴ idiopathic.^{15 16}

Various food stuffs may interfere with the proper absorption of calcium in the body. The depressive effect of phytic acid,¹⁷ fats,¹⁸ and oxalic acid as in spinach,¹⁹ have been reported.

Doubt as to the value of dicalcium phosphate as a source of calcium has been raised by recent work showing the depressing effect of phosphorus on calcium absorption. The findings of Newman,²⁰ Leichsenring et al,²¹ and Page and Page,²² have indicated that the ingestion of phosphorus either by diet or as a mineral supplement, appears to play an important part in preventing calcium absorption and in lowering the blood calcium. Page and Page claim from a 10 year study, that dicalcium phosphate contributes to muscular irritability or cramps. This is attributed to a decreased calcium absorption from the intestinal

Presented at the 105th Annual Session of the Medical Association of Georgia, May 1-4, 1955, Augusta, Ga.



Osteoporosis—Hand (before)



Osteoporosis—Hand (after three months)

tract resulting from the inverse ratio between calcium and phosphorus, which is produced by the ingestion of the phosphate salt. Gross, Wager, and Loving,²³ have corroborated the above findings on their series of 40 patients.

The observation that drinking milk is of no value and in fact is actually detrimental to the treatment of osteoporosis is not generally realized. Textbooks on diet still advise drinking of milk for calcium deficiencies because of its high content of calcium. However, the bulk of the calcium in milk is held in combination with protein and is inert, and so passes through the body. The phosphorus of milk can prevent or hinder the calcium absorption and thus actually lower the blood calcium level. It has been shown by Page and Page,²⁴ and Wolff,²⁵ that leg cramps in pregnancy could be induced by the intake of large quantities of milk, and prevented by reducing or omitting milk. Furthermore, Page and Page determined the blood calcium levels of 10 women with leg cramps and whose diffusible calcium was lowered, but whose inorganic phosphorus was raised. By limiting the milk intake and thus increasing the elimination of phosphorus, the blood level of diffusible calcium was raised and the blood level of phosphorus was lowered. This inhibiting influence of milk on calcium absorption in the body has been observed by one of the authors for some years. We have seen patients whose teeth have been found to have 20 or 30 new cavities in one month and who

have marked decalcification of the hand bones while they were drinking one quart of milk per day.

It has long been recognized that calcium in plasma exists in two distinct fractions, commonly termed diffusible and non-diffusible calcium. It has also been established that diffusible calcium is physiologically active, while the non-diffusible fraction is physiologically inert. The non-diffusible calcium is bound to the serum proteins, while the diffusible fraction is generally considered to be in the ionic form. This ionic calcium is intimately related to the phosphate ion, since an inverse relationship between the two ions has been noted in the blood. Thus, estimation of the total calcium values is often misleading, without the diffusible values also. Ionized calcium or diffusible calcium is a term referring to a value calculated from total serum calcium and total serum protein by the normogram of McLean and Hastings.²⁶

The importance of calcium to the body economy is shown by the fact that 99 per cent of the skeleton is calcium. Calcium is necessary for the normal action of the heart; it aids in nerve conduction and in the energy exchange of muscle contraction; it influences the growth of specific organs; it is of value in the absorption of the end products of digestion; it retards intestinal putrefaction. According to Shipley, Kramer, and Howland²⁷ and Sendroy and Hastings,²⁸ the utilization of calcium is dependent on the solubility product of some sparingly soluble calcium and phosphate containing salts.

This report is on 20 patients, discovered within the past one and one half years and who have been under treatment for varying periods of time. One of these was a male with marked degeneration of the right ramus of the mandible, with normal calcification of the other ramus. This patient was not followed up, but is mentioned because of the rareness of his condition. Of the remaining 19 cases, eight have already shown noticeable increase in bony calcification; five have had slight improvement; and six have had no improvement. Of the last group of six, with no improvement, one has been under treatment for one month only.

Using the critical point of Page²⁹ . . . total calcium 8.75 mg. per cent, seven patients had calcium determinations below this level. No case had abnormally high total calcium, and the average total calcium for our series was 8.88 mg. per cent. Below the critical level of 8.75 per cent there is withdrawal of minerals from the dentine and bone. The critical point for phosphorus is 3.5 mg. per cent. All of our cases tested showed levels at or below this point. There was no change in the diffusible calcium levels from normal. The average was 4.43 mg. per cent. The blood cholesterol mean was 197.47 mg. per cent.

The basal metabolic rates ran on the minus side, ranging from minus three to minus 32 per cent, the only exception being a plus six. The average BMR was minus 13.1 per cent.

In view of the reported ill effects of milk drinking on calcium absorption, it is of interest to note that many of these patients drank milk in large quantities,

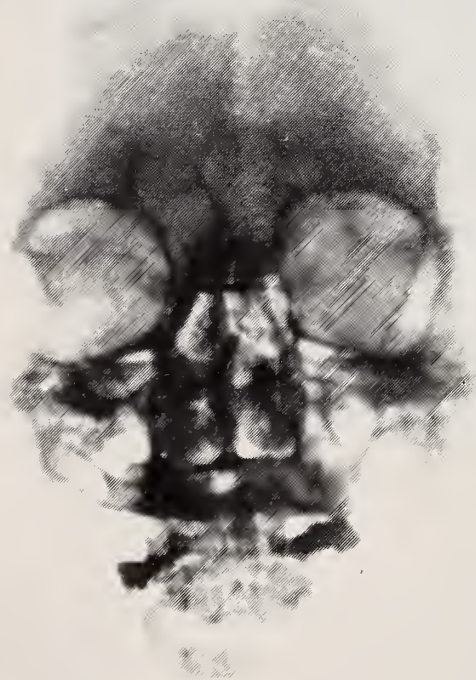
the largest amount being four quarts daily. Similarly, the history of a highly acid diet was commonly encountered (14, or 70 per cent). The mean HBG was not remarkable (81 per cent).

There were only three males in the series, 17 being females. The age differential between the sexes was males—30.3 yrs., females—38.7 yrs. However, the series is too small for definite conclusions.

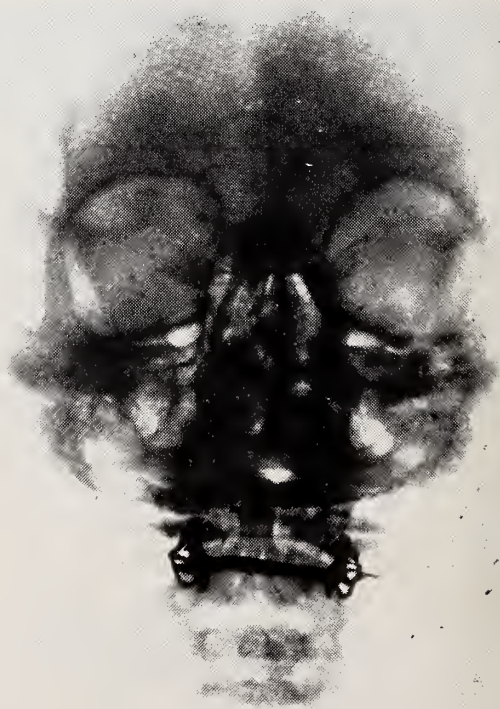
The diagnosis of peridontoclasia in each instance was made by Dr. S. P. Vail, professor of dental diagnosis, or his assistant Dr. Etheridge, of Emory University School of Dentistry. The diagnosis of decalcification or osteoporosis and endocrine disorder was made by the medical consultant. The type of endocrine disorder was usually thyroid insufficiency. There was one case of hyperthyroidism. Most of the females showed some degree of hypoestrinism. Four females, whose ages were 16, 27, 25, and 22, showed normal estrin smears.

Treatment consisted of necessary dental and gum work; omitting milk from the diet; taking bone meal and vitamin tablets; thyroid extract in the hypothyroid cases; estrin in selected cases; low acid diet; and in one instance anti-thyroid drugs. Biliary dyskinesia was encountered rather frequently and treated accordingly.

Results of treatment were encouraging. Whereas in the past absorption of calcium into the bones has been a matter of months and years, and in many cases of no avail (West³⁰), there has been visible improvement in many of these patients. The first improvement reported was in the condition of the



Osteoporosis—Mandible (before)



Osteoporosis—Mandible (after)



Peridontoclasia (before)



Peridontoclasia (after)

gums and teeth. Many times teeth have been saved which had been marked for extraction. The prognosis of these cases without treatment is to progress swiftly to the point of complete dentures which would not hold, due to continued destruction of the mandible. Under treatment, we have seen this process of bone absorption halted and a process of calcium replacement begun, in the space of a few months. In one case the change was evident to the dentist in weeks.

Summary

A series of 20 patients whose cases were diagnosed as osteoporosis, peridontoclasia, and endocrine disorder have been treated for variable times during the past 18 months. This syndrome is probably much more common than it is thought to be. Many of these were heavy milk drinkers (up to four quarts daily). Nearly all had a highly acid diet. The blood calcium was normal. The basal rates were relatively low, averaging minus 13.3 per cent. Only three were males. The endocrine disturbances encountered were chiefly hypothyroidism. One case of hyperthyroidism was found. Several patients showed hypo-estrinism. No hyperparathyroidism was proven. Treatment consisted in omitting milk as a beverage, giving bone meal and vitamins, and omitting highly acid foods, together with general hygienic measures including dental work. Biliary dyskinesia was treated when found in a number of patients. Marked improvement in the peridontoclasia and osteoporosis occurred in 42 per cent, slight improvement in 26 per cent, and no improvement in 32 per cent. Several of those showing

no improvement had been under treatment for only a short time. X-rays showed relief from pyorrhea and some degree of bone regeneration in 68 per cent. The name of Vail's syndrome is suggested for this group of cases.

Conclusions: The detrimental effect of drinking milk on peridontoclasia and osteoporosis is emphasized. There is considerable doubt as to the value of dicalcium phosphate with viosterol in this condition. Thyroid extract, estrin, bone meal, and vitamins, with a low acid diet seemed to have a beneficial effect on peridontoclasia and osteoporosis. Further work is necessary to properly evaluate these findings, but the preliminary work is encouraging. Close cooperation between dentist and internist is essential.

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Georgia Physicians Report Venereal Diseases

GEORGIA'S PRIVATE PHYSICIANS have been doing an excellent job of reporting venereal diseases to the Georgia Department of Public Health under the Department's new reporting system. The system was begun July 18, 1955.

This information comes from T. F. Sellers, director of the Department, who said that of all the physicians who see cases of venereal disease, 93 per cent report their diagnoses. "To our knowledge," Dr. Sellers said, "no other State Health Department enjoys such splendid cooperation in this important work."

From July 18 to December 1, 1955, a total of 804 physicians have reported 1,278 cases of syphilis. Venereal disease reports from private physicians totaled 1,974. Only 60 physicians, or seven per cent of the total, did not report or respond in any way to our program.

Other sources of case-finding have reported 1,028 cases of syphilis, 6,056 cases of gonorrhea, and 220 cases of other venereal diseases. Case-reporting by physicians is a rapidly growing source of much needed information.

"In behalf of the people of Georgia, we in the State Health Department appreciate this cooperation from the physicians," Dr. Sellers continued. "Only by receiving these reports can we be aware of our venereal disease problem and effectively help the doctors who seek to eradicate this disease. May we again remind all physicians that we are only interested in the statistics which these reports give us. The confidence of neither the doctor nor the patient will ever be violated.

Syphilis	
Primary and secondary	70
Early latent	289
Late latent	755
Cardiovascular	35
Central nervous system	27
Other late	4
Congenital	56
Unknown stage	42
Total syphilis treated	1,278
Prophylactic treatment	24
Previous adequate treatment	513
Total syphilis reported	1,815
Other	
Gonorrhea	15
Lymphogranuloma venereum	3
Chancroid	2
Granuloma inguinale	1
Total	21
No. venereal diseases	111
Total reports	1,947

"The physicians who have reported the above 70 cases of primary and secondary syphilis have in every instance permitted our well-trained interviewers to interview these patients for their contacts.

"It is very commendable that these physicians have allowed these investigations of contacts, since epidemiology is the backbone of control. All information gathered through investigations is kept absolutely confidential."

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J. M. A. GEORGIA

The Philosophy in Office Procedure

JOHN R. FOWLER, M.D., Barre, Mass.

THE DEFINITION OF *Philosophy* is, "The knowledge of the questions of all phenomena, both of mind and matter; reasoned science; practical wisdom; a particular system; calmness of temper."

The definition of *Procedure* is, "manner of proceeding; conduct; process."

The definition which concerns us here is "reasoned science." Therefore, in applying this philosophy to office procedure, it is imperative to have detailed knowledge of not only the procedure, itself, but the reasons for the procedure, based on experience and scientific data; the immediate effect of the procedure on the patient; and the end results also based on scientific data and reasoning.

This means that, in order to apply any procedure, one should be aware of the full history of the condition for which the procedure is given, of the immediate effects, and the expected results so that the prognosis can be rendered with reasonable certainty.

A typical example of this philosophy is the use of penicillin prior to or immediately following extraction of an infected tooth. It is known that immediately following the extraction of a tooth the blood stream is flooded with the released organisms. It is known that in the past such a release of organisms has been followed by bacterial endocarditis. It is known that with antibiotic treatment endocarditis can be prevented or cured. Therefore, in the use of penicillin the reason for giving it and the expected result is based on "reasoned science."

Whether or not this procedure should be followed in all cases routinely is a matter of individual judgment, always bearing in mind the fact that many antibiotics are given needlessly. Careful consideration should be given before antibiotics are used routinely, and there should be good reason for such use.

Another office procedure which meets the test of "reasoned science" is the use of the "Papanicolaou test." This is a valuable test, much too sparingly followed in office procedure. There are now consecutive cases amounting to the tens of thousands which give a very factual and compelling reason why this test should be done much more often than is now the custom.

Thirteen years ago, I had my first indoctrination in the "Papanicolaou test." This procedure, along with the vaginal smear, was hailed as a great advance in the possibility of early recognition of cancer of the cervix, uterus, and vagina.

The slowness of the recognition of this method and its application was due largely to the fact that few cytologists were trained to properly interpret the findings. However, sufficient data has been obtained, and in every large area cytologists have now been trained to properly interpret the results of Papanicolaou test, and to make definite statements as to its value.

The test itself is simple. The technique preferred by many is the simple aspiration with the curved glass tube of material from the posterior cul-de-sac and the cervical canal. This material is smeared on clean slides—thin enough for examination—one for material from the cul-de-sac and one from the cervical canal. These are immediately immersed in equal parts of ether and 95 per cent alcohol and sent to the cytologist for examination. If this be done with many cases routinely, the average results to be expected would be 95 per cent negative, four per cent doubtful, and one per cent positive. The cytologist has five classifications of these smears: the first two—negative; the third—doubtful; the fourth—probably positive; and the fifth—positive.

Of the positive smears, 68 per cent may be expected to be found in cases presenting no signs or symptoms of cancer. This is a significant finding. In the case of positive findings, further testing and possible biopsy are essential.

The Shiller test, which was so long used for examining the cervix, whereby an iodine solution was painted on the cervix and any unstained area suspected, is, to my mind, a rather poor test and need not be done. More effective and more reliable is the simple wiping of the cervix with a pledget of cotton on an applicator, and, if there is bleeding at any point, that point should be suspected and a biopsy taken. The only instruments needed in any of these tests is a speculum, hook, sound, curette, aspirator, and forceps.

In discussing the "Papanicolaou test" alone, I shall not go into the field of biopsy and further testing to

Presented at the 105th Annual Session of the Medical Association of Georgia, Augusta, May 1-4, 1955.

prove the location of the cancer. I have been told that Papanicolaou is now carrying on a series of tests whereby the vaginal smears are obtained by having the patient use a tampon insert for 24 hours, after which time it is put into the fixing solution for examination.

I feel impelled to discuss at this time the subject of poliomyelitis immunization. With all the emotional reactions and lack of complete factual information, I feel that it should be discussed fully.

There are those who feel that the timing of the release of information by the Foundation for Infantile Paralysis was unfortunate. Bear in mind, however, that there were sentimental reasons for having this information released on April 12, the tenth anniversary of the death of Franklin Delano Roosevelt. The fact is that the report indicates that successful immunization can be had for polio. This information came too close to the beginning of the polio season. There will, therefore, during the entire polio season, be continued confusion as to the use of the vaccine. It is inevitable that the vaccine will be used in many cases where polio is already incubating. Since it takes the vaccine approximately four weeks to develop protective antibodies, it is obvious that many individuals receiving the vaccine will come down with the disease. This will lead to further confusion, particularly among the emotionally tense laity. In the overall analysis of the incidence of polio, it is impossible to predict the shifting areas where the incidence will be greatest. The areas where such incidence has been greatest over the past few years are known, but there is an unpredicted geographic shifting of greatest incidence. Therefore, the application of immunization, this year, will inevitably be attended with high emotional reactions. However, reasoned science can still be applied, but it will take a lot of

understanding on the part of the physician and a lot of patient explanation to the public. This can best be done by the individual physician who has a solid background of information as to polio incidence. Statistics prove that in the Southern States, and extending westward through middle California, the incidence of the disease occurs earlier and in a younger age group; this is true also in the Northern Pacific and the Northeastern regions. In the Southern area, the incidence is highest among the group aged *one to five* and, in many instances, strikes the *one year old* group. In the Northwestern sections and in New England and contiguous states, the incidence is highest among the ages from *five to nine*. The highest overall incidence is ages *five and six*. The next highest incidence is found in those ages *nine to 14*. The third highest is among those *15 to 19*. Pregnant women are more susceptible by approximately three to one than non-pregnant women of similar age. However, the severity of the infection is much less, and there are many fewer cases involving the upper part of the body. Likewise, the death rate is lower, and severe paralysis is also less.

Because of the short supply of vaccine, each state has the responsibility to see that the available supply is properly distributed and that the more susceptible age groups be given priority over the others. This will obviously keep the vaccine, this year, from many who might otherwise be saved by immunization, but it will still be fair and equitable. The responsibility of the individual physician in his office is to know these facts and explain them carefully to his patients and emphasize the fact that the person without a dime has the same priority as the person with a million dollars. It is up to the individual physician to see that this equity is maintained.

Fowler Clinic

Selective Service System to Call Physicians

THE NEEDS OF THE MILITARY services for medical officers from July 1, 1956, to June 30, 1957, will be of such magnitude as to require active duty of all interns and residents who have not satisfied their military liability, and perhaps some liable physicians of Priority III who are older and who may be established in practice.

In view of this it will not be possible to support deferment for any current intern for residency training except those included in the Department of De-

fense's Residency Consideration Program and perhaps some in most exceptional situations necessary to the national health, safety, or interest. Others will be called by Selective Service as needed through the year unless they voluntarily obtain commissions before they are called.

The President will probably direct the Selective Service System to issue calls for physicians to enter service during the course of the hospital year—possibly in October 1956 and January and April 1957.

Cultists, Expediency, And Responsibility . . .

THE VERY SIGNIFICANT ACTION taken recently by the Georgia General Assembly to prohibit the pseudo-medical practice of a cult within the State represents a monumental step in the betterment of the public welfare and the protection of our citizens. The keen interest and sense of responsibility demonstrated by numerous doctors over the State in securing the repeal of the law licensing these individuals to practice has been truly remarkable. We are encouraged to believe that this represents a renaissance of concern of doctors for matters primarily concerning the public welfare. Most of us are justly accused of being so wrapped up in our profession, and in activities directly relating to it, that we devote little time or effort to those issues which should be of primary concern to us as citizens in an integrated community.

The issue of the above mentioned cultists, we feel, is a genuine exception to this tendency. Since the true character of this cult has been so thoroughly investigated and demonstrated by the assistant executive secretary during the past year, medical societies and lay groups alike have been moved to end this threat to the people. After learning the true nature of the cult, no responsible person could feel that organized medicine could be hurt competitively by these charlatans. Only uninformed people could possibly be harmed by these quacks. Once apprised of this creeping danger, doctors responded admirably in their efforts to inform and educate the people in their communities. Once informed, the responsible citizens of Georgia acted through their representatives in both houses of the General Assembly to halt this menace in our midst.

Because of their training and insight in the healing arts, physicians were the logical leaders in such a campaign for public education. By utilizing their resources and achieving the almost unanimous repeal of that ill-advised licensing act, the doctors of Georgia have helped not only the man in the street, but have increased the stature and general prestige of the profession. Our prestige has been bolstered because of our awareness of an issue of public concern and our willingness to go to bat for a cause which we knew to be just.

In our profession, we find ourselves in a peculiarly advantageous position to effect actions for the public good, if we could only bring ourselves to realize

our responsibilities as citizens, not only in our individual communities, but in the state and nation as well. No single group of informed citizens is so free to speak out and to speak without fear of reprisal from opposing pressure groups. A doctor who practices good, honest medicine in a community where he is needed and whose conduct is that of a gentleman, is without peer as a person of influence. With the advantage of superior education, public respect, and influence, we must (whether we like it or not) accept the position of responsibility in which most of us find ourselves and speak out on public issues which we know to be vital. Rather than hurt ourselves and our profession, we can improve its standing and prestige immeasurably.

What other group in this "land of the free" is so immune to pressures? Almost daily we hear someone comment that we are all tied to our pocketbooks and that almost everyone sacrifices principle to expediency. The poor clerk must bow to his boss whatever the circumstances; the minister is in principle subservient only to God, but for the budget he may be forced to acquiesce to the wishes of the rich parishioner; the newspaper editor knows well to delete any news item that might put the owner or publisher in a poor light; the university or college president, who pays lip service to academic freedom, in the final analysis often has to bow to the board of trustees, regents, football-crazed alumni, and so on down the line. This is meant as no condemnation of these people; it is one of the sad realities of life. There are many stout hearts in all walks of life who want desperately to speak out for what they know to be right but who out of fear for their jobs and their futures must remain silent.

We are in a position to speak for these people as well as for ourselves. Let us not remain silent, for we shall not pass this way again.

Salute the Gray Ladies of the American Red Cross

THIS MONTH'S COVER salutes the Gray Ladies of the American Red Cross. Almost every doctor in Georgia is aware of the tremendous contributions that these women make in their voluntary services to hospitals and other medical facilities.

The Gray Ladies service was organized in 1918 at Walter Reed Hospital. Initially it was known as the Hospital and Recreation Corps, but the name

Gray Ladies was soon given the members of the Corps because of the official uniform of gray dress and veil.

In their early days, the volunteers were concerned primarily with hostess and recreation duties. The return of the sick and injured from the European battle fields in 1918, together with the many casualties of the flu epidemic, caused the need for more direct services to individual patients. Today, their work is primarily dedicated to the comfort and recovery of the sick, the injured, and the handicapped. Typical services which they perform in the hospital and the clinic are: visiting patients in wards and at the bedside; arranging and distributing gift flowers; shopping for patients; playing and teaching games; planning entertainment for patient participation; assisting patients with correspondence; assisting social workers; serving as guides to visitors and entertainers; acting as hostesses in recreation rooms; teaching music, foreign languages, or other subjects; acting as translators; serving in libraries, sorting books, and delivering reading material to patients; teaching simple handicrafts; staffing an information desk for patients and visitors; working with special patients such as the blind, tubercular, or mentally ill.

In Georgia during 1955, there were 6,120 active Gray Ladies, including 875 in military hospitals, 872 in veterans' hospitals, 424 in military installations, 60 in civilian mental hospitals, 2,736 in other civilian hospitals, 175 in other institutions and agencies, 379 in the blood program, and 562 in all other services. Many more Gray Lady groups are being activated in Georgia to serve in the new Hill-Burton Hospitals.

The training of Gray Ladies is under the direction of members of the medical staffs of hospitals, etc. The training course consists of approximately twelve hours of instruction covering such subjects as Red Cross orientation, hospital or clinic orientation, duties, and responsibilities.

The Gray Ladies of Georgia are to be congratulated and commended for the tremendous job that they so cheerfully do in the medical field.

1954—One in Four Georgia Mothers Delivered by Midwife

THE MEDICAL ASSOCIATION OF GEORGIA'S Maternal and Infant Welfare Committee and the Georgia Department of Public Health are concerned that although the number of mothers being hospitalized for delivery has increased sharply this happy trend is

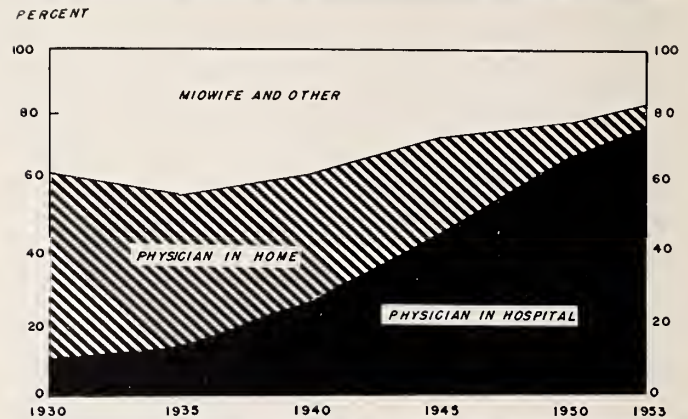


Figure 1

Live Births—Percentage Distribution by Attendant—Georgia, 1930-1953.

less evident in deliveries by midwives than in the group of mothers who were formerly delivered by physicians at home. (Figure 1)

The 1955 Midwife Act, effective as of January 1, 1956, can, however, offer increased protection for the mothers and infants who apparently for a time will continue to have local lay midwives officiate at their deliveries. Chiefly affected will be approximately 14,000 to 15,000 mothers out of the 58,000 delivered in 150 counties where one of four is attended by persons other than physicians. (Table I)

What are some of the things the law provides which are of particular concern to physicians?

Since 1925 the only legal requirements for a midwife were that she (1) cause a specimen of blood to be drawn prenatally and tested for syphilis, (2) register births, and (3) use prescribed eye prophylaxis. The new law provides, Section 9, "That it shall be unlawful for any person holding a certificate as a midwife to attend any except cases of normal childbirth as defined herein—, or to perform any internal examinations or manipulations of any kind."

The legal definition of the term "normal childbirth" includes physician responsibility—"delivery, at or close to term, of a pregnant woman whose physical examination by a physician reveals no abnormalities, and who does not have signs or symptoms of hemorrhage, toxemia, infection, abnormal position, and/or presentation or prolonged labor." (Section 1)

The Act also provides for revocation of certificates and punishment for violation. The inclusion of an injunctive clause is considered important. Such actions were not possible in the past.

Although Utopia cannot suddenly be achieved, goals are set towards which to work and obviously, here, as with all progress, increased privilege brings increased responsibility. What are the implications for physicians, for communities, and for health departments?

TOTAL LIVE BIRTHS AND MIDWIFE DELIVERIES, SPECIFIED COUNTIES AND REMAINDER OF STATE, GEORGIA, 1954
Area

Area	Total Live Births		Midwife Deliveries	
	Number	Per-cent	Number	Per-cent
State Total	190,191	100.0	15,459	15.4
Bibb	3,493		44	
Chatham	4,994		25	
Cobb	2,312		19	
DeKalb	5,582		36	
Floyd	1,551		91	
Fulton	13,282		37	
Muscogee	5,129		96	
Richmond	4,229		28	
Troup	1,351		268	
Nine Counties total	41,923	41.8	644	1.5
Rest of State (150 co.)	58,268	58.2	14,815	25.4

SOURCE: Georgia Department of Public Health
Central Statistical Unit

Table 1

Legally, if a midwife delivery is planned, each prenatal, wherever it is possible, will now have to to have at least one careful and complete physical examination late in pregnancy. Ideally, good, continuous, prenatal supervision and care should be given throughout pregnancy. In some areas in the state this provision may for awhile still offer problems for physicians and public health workers and for midwives and their patients. Moreover, now, each midwife will have to have a complete physical examination annually to determine her continued physical and mental fitness. This should not be so difficult to achieve since there are only eleven hundred midwives left, and the number is decreasing.

If the midwife is to comply with the terms of the law, delivering only cases of "normal childbirth," planned provisions for medical assistance and, if necessary, hospitalization will have to be made available by physicians and by communities for abnormal obstetrical care. Again there are areas in the state which for awhile may continue to offer problems, but it is a goal worth working toward.

In areas where midwives are considered necessary, the Health Departments will continue to be responsible for teaching, supervision, and certification of these midwives in order to make sure that they conduct normal labors in the most adequate way and are able to recognize abnormalities, and ask for help when they appear. This, too, will offer problems since there are about 20 counties with no local health personnel.

Special plans will also have to be made in counties where there is no physician and/or organized health department and/or hospital.

On the brighter side if physicians, singly or in groups, hospitals and local health departments work closely together in planning and in responsible action, we can at least partially compensate until adequate prenatal and postpartal care and physician-

hospital delivery service can become a statewide reality for all obstetrical cases and newborn infants.

(For your information, copies of the Midwife Act and of the proposed rules and regulations are available on request from the Georgia Department of Public Health.)

Helen W. Bellhouse, M.D.

Newer Corticoid Steroids

AFTER NEARLY A YEAR of clinical application of prednisone (meticorten, metacortandracin) and prednisolone (meticortelone, metacortandralone) it seems appropriate to reappraise these new corticoids as to clinical response and toxicity.

Prednisone is the analogue of cortisone and prednisolone is that of hydrocortisone. Each is identical in structure to its precursor except that through loss of two hydrogen atoms from one of the benzene rings, a double bond is formed making the new products far more active chemically than the old, especially in antirheumatic activity. In the latter respect the new corticoids are three to five times as active as the old, mg. for mg., while remaining the same or perhaps a little less active in salt retention and potassium loss. Thus at therapeutically effective dosage levels the sodium and potassium effects are negligible. However, when large doses are used these effects may be appreciable, contrary to the general concept. Pharmacologic tests indicate that prednisone is about 80 per cent as active as prednisolone, but clinical assessment has revealed little if any difference in the two except that prednisolone is effective when given into affected joints locally whereas prednisone is not. Forty mg. of plain ACTH (given 10 mg. every six hours) makes a cortisone response equivalent to 100 mg. ACTH-Gel is two to four times as effective as plain ACTH given in four divided doses daily. Therefore, 40 mg. of ACTH-Gel is roughly equivalent to 100 mg. of prednisone in antirheumatic activity.

The effect on carbohydrate metabolism is about the same as that of cortisone in comparable dosage so that little trouble may be anticipated except in latent or overt diabetic subjects.

Protein breakdown or catabolism with the new steroids is similar to that of cortisone in therapeutic dosage. Thus caution must be used in patients with renal failure. The catabolic effect also means that bone matrix will be broken down, osteoporosis can occur with prolonged treatment, and calcium excretion will be increased. Thus these steroids must be used with caution in osteoporotic patients and in patients with a tendency toward formation of calcium-bearing renal stones.

The sedimentation rate falls non-specifically and so cannot be used as a guide to therapy.

The same masking of the clinical signs of infection are apparent with these substances as with the older ones so that fever, pain, and inflammation may not occur with infections. Leukocytosis occurs regularly from administration of the drugs so that leukocyte counts are of little value in detecting concurrent infection.

Reduction in resistance to tuberculosis is no different from that seen with cortisone and ACTH so that patients receiving prolonged therapy should have chest films, and, if even fibrotic tuberculous lesions are apparent, antituberculous drugs should be employed concurrently.

Epigastric discomfort and duodenal ulcer have occurred somewhat more frequently with the new steroids. It may be advisable to use antacids or acid-suppressive drugs regularly with them.

Sleeplessness and psychoses, increased sweating or flushing, moonface, weakness and fatigue, hirsutism, and acne and leg cramps are found with about the same frequency as with cortisone and ACTH.

Reports suggest that the new preparations may be effective in many cases of rheumatoid arthritis in which cortisone has either failed or ceased to be effective. While early papers indicated a lack of relapses by patients still under treatment, later evalua-

tions show a considerable number. Also in comparable dosage (4:1) some patients have responded to cortisone where prednisone has failed.

Asthma, according to several observers, seems to respond more readily to prednisone than to cortisone.

Results in six cases of scleroderma reported and in two cases seen by this writer have shown considerable lessening of stiffness and decrease in joint pain and swelling.

Several observers, including this writer, have noted improvement in disseminated lupus erythematosus in which ACTH and cortisone have failed.

We have had an excellent result in one case of temporal arteritis employing a dose starting at 30 mg. a day.

In the nephrotic syndrome the absence of salt retention by prednisone provides an advantage over the older preparations. Doses of 100-120 mg. a day may be needed.

In other diseases the response to the newer corticosteroids is about the same as to the old except that the dosage ratio is about 1:3-5.

9-Alphafluorohydrocortisone is another new preparation with potent antirheumatic qualities, but its electrolyte effects are so potent that it cannot be used. It is employed locally as a salve or lotion. A word of caution needs to be uttered in this regard. Several cases of fairly marked edema have been reported from applying this steroid locally as a lotion or ointment to lesions covering a large surface area. Thus it is apparent that considerable systemic effect can result from local application.

Public Opinion on Physicians and Public Health

FORTY PER CENT of the adult population believe food costs are much too high; 45 per cent believe repair charges (TV, auto, etc.) are excessive; 27 per cent are equally critical of clothing costs, and only 26 per cent believe that the cost of medical care is much too high.

These figures are from a report of a national survey of opinions and attitudes toward medical care recently released to the pharmaceutical industry by the Health Information Foundation of New York.

The study is one of several current socio-economic surveys in health initiated by the foundation.

Findings of special interest include:

—While medical costs in general come in for less criticism than other elements of the cost of living, within the category of medical costs the percentage believing costs "much too high" for doctors' fees is 16 per cent; hospital charges, 39 per cent; dentists'

fees, 24 per cent; prescriptions at drug stores, 38 per cent.

—When asked, "What are some of the things that make it easier to have good health today than it was 30 years ago?" 71 per cent cite improvements in medical knowledge and facilities, and almost half the population—47 per cent—specifically refer to new drugs, medicines, and vaccines now available.

—To the question, "What people or groups do you think have been mainly responsible for these new 'wonder' drugs?" only 11 per cent of the respondents give specific credit to the drug companies, pharmaceutical houses, the chemical industry, or drug manufacturers; an additional nine per cent mention "laboratories"; 23 per cent credit doctors, the American Medical Association, or groups of doctors; 40 per cent credit scientists, science, research, or persons such as medical researchers and chemists.



physician's bookshelf

Books Received

De Lee, Sol T., M.D., *Safeguarding Motherhood*, J. B. Lippincott Company, Philadelphia, 1953, 140 pp.

Lectures on the Scientific Basis of Medicine, Vol. III, John de Graff, Inc., New York, 1955, 398 pp., \$6.00.

Koskowski, W., M.D., *The Habit of Tobacco Smoking*, John de Graff, Inc., New York, 1955, 292 pp., \$5.00.

Ishmael, William K., M.D., and Shorbe, Howard B., M.D., *Care of the Back*, J. B. Lippincott Company, Philadelphia, 1953, 22 pp.

Reviews

Cantarow, Abraham, M.D., and Trumper, Max, Ph.D., *CLINICAL BIOCHEMISTRY*, 5th Edition, W. B. Saunders Company, Philadelphia, 54 figures, 738 pp., \$9.00.

This excellent textbook discusses the metabolism of the major organic and inorganic chemical substances in the human diet and in the human body fluids and tissues. It contains an excellent discussion of the meaning and interpretation of laboratory tests of the various metabolic functions. The clinical applications of the biochemical knowledge are clearly outlined. The authors include a brief discussion of abnormal findings in various diseases and clinical conditions. The normal and pathologic physiology of the various chemical constituents of the body are discussed. The book also contains discussions of other clinically important subjects such as water balance and neutrality regulation. Other basic physiological functions discussed include respiratory exchange and basal metabolism. There is an excellent chapter on hormone assay and endocrine function. There is also a chapter on the vitamins.

The book also contains a discussion of functional tests of stomach, liver, pancreas, and kidneys. There is also a chapter on cerebrospinal fluid in health and disease.

This is an excellent non-technical book on clinical biochemistry. It is a good source of a wealth of information on this subject for the busy clinician. It should also prove to be a good textbook for medical students.

Arthur M. Knight, Jr., M.D.

Cowdry, E. V., Director, Wernse Cancer Research Laboratory, Washington University, St. Louis, *CANCER CELLS*, W. B. Sanders Company, Philadelphia, 1955, 677 pp, 137 fig., \$16.00.

This book is certainly a complete and thorough study of cancer, especially from a research standpoint. It is amazing how such a vast amount of material is covered in one book. It is masterfully arranged, and in order to aid one who wishes to use the book for quick reference, each chapter has a summary in which the "meat" of that chapter is presented.

In Chapter I, the author distinguishes between malignant and benign tumors, and in the other chapters he discusses the properties of malignant cells, distribution of malignant potentialities in normal cells, agents "causing" malignant transformation, along with susceptibility of normal cells to these carcinogens.

Not only does he discuss the research angle, where he gives the achievements and handling of cancer research, but he also discusses the diagnosis, treatment, and prevention of cancer.

I certainly recommend that this book be in the possession of all those interested in cancer, not only from the standpoint of research, but also diagnosis or treatment. It should be in the library of every medical school and hospital.

Milford B. Hatcher, M.D.

Tauber, Robert, M.D., F.A.C.S., *BASIC SURGICAL SKILLS, A MANUAL WITH APPROPRIATE EXERCISES*, W. B. Saunders, Philadelphia, 1955, 77 pp., \$3.75.

Medical students in general will appreciate the practical help extended by this manual. Basic surgical techniques are explained in detail with numerous simplified diagrams. The lost art of square knot tying is reemphasized and pictured in a clear, concise fashion. Helpful hints in regard to hemostatic sutures are presented, and fundamental surgical stitches are illustrated so clearly that deft movements by skilled fingers will no longer baffle the student assistant. Unfortunately many surgical curricula frequently neglect the teaching of basic surgical techniques. Most medical students are able to recite the detailed maneuvers that are required in performing complicated cancer operations; however, when confronted with the practical problem of suturing a small laceration, they frequently feel inadequate. The need for a helpful guide in acquiring necessary basic surgical skills has been met by Dr. Tauber's manual and his "training board."

Milton F. Bryant, Jr., M.D.

Georgia Heart Association Clinics

GOODLOE Y. ERWIN, M.D., Athens, Ga.

THE GEORGIA HEART Association Clinic system was founded to supplement the care of indigent cardiac patients in the state. It has been a cooperative project in which the efforts of the State Health Department, local health departments, local hospitals, and voluntary organizations have been coordinated. The clinics are staffed by local physicians who have volunteered their services without compensation. The clinics give both consultant services and direct patient care.

New patients must be referred by physicians and be certified as indigent by the welfare department of the county in which the patient resides. There are no age limits for the patients.

New patients give a history and receive physical examinations, electrocardiograms, heart fluoroscopy, and other laboratory work. A report of these findings is sent to the referring physician. Unless distances are too great, the patient is usually followed in the clinic. However, drugs must be furnished by the patient's home county.

When special studies, such as cardiac catheterization or angiocardiology, are needed they are obtained at one of the Atlanta or Augusta clinics. If cardiac surgery is indicated, this can usually be arranged through either the Crippled Children's Program; the State Aid Program at Augusta, or through

Prepared at the request of the Committee on Professional Education of the Ga. Heart Assn.

the State Department of Vocational Rehabilitation.

If hospitalization is indicated for medical treatment, difficulties may arise if the patient lives outside of the county in which the clinic is located. However, some clinics are able to arrange for hospitalization of their patients. In-patient treatment of rheumatic fever patients can frequently be arranged at Aidmore, and the State Aid Service at Augusta can sometimes help with such cases.

Transportation to and from clinics is frequently a problem. In some areas, this has been solved by County Heart Councils, which furnish transportation when it is not made available by friends, relatives, or by the local welfare departments.

Heart clinics are located in Albany, Athens, Atlanta, Augusta, Brunswick, Columbus, LaGrange, Macon, Savannah, Thomaston, Thomasville, and Waycross. It is hoped that new clinics can be established in North Georgia. At present, patients from all of Northeast Georgia can be referred to the Athens Clinic. The Giddings Memorial Clinic, at St. Joseph's Infirmary in Atlanta, can accept patients from all of Northwest Georgia in addition to counties around the Atlanta area. In general it is best to use the clinic which is closest to the patient's residence.

Interested physicians are invited to come to the clinic with their patients when possible. Application forms and clinic schedules can be secured by writing the Chief of Heart Clinic at the clinics listed on the following page.

Symposium on the Diagnosis and Treatment of Congenital Heart Disease

March 22-24, 1956—Academy of Medicine, 875 West Peachtree St., N. E., Atlanta

Sponsored by the Medical College of Georgia, Emory University School of Medicine, State Health Department, and Georgia Heart Association. The symposium is designed for internists, radiologists, and thoracic surgeons. Participants will include Dr. C. Walton Lillehei, Cardiovascular Surgeon, University of Minnesota Medical School, Minneapolis; Dr. Edward B. D. Neuhauser, Radiologist-in-Chief, Children's Medical Cen-

ter, Boston; and Dr. S. Gilbert Blount, Jr., Cardiologist and Associate Professor of Medicine, University of Colorado Medical Center, Denver. Moderators for the sessions will be the following Georgia physicians: J. Gordon Barrow, Noble O. Fowler, R. Bruce Logue, A. Calhoun Witham, T. Sterling Claiborne, and J. Willis Hurst. For information write to Dr. Barrow at 1123 Gordon St., S.W., Atlanta.

Heart Association Clinics in Georgia

Albany Heart Clinic
Dougherty County Health Center
P. O. Box 127
Albany, Georgia

James A. Redfearn, M.D.
Chief of Clinic

Mrs. Anne Sulenski
Clinic Secretary

Athens Heart Clinic
Michael Memorial Clinic Bldg.
Athens, Georgia

Bollings DuBose, Jr., M.D.
Chief of Clinic

Mrs. H. B. Harris
Clinic Secretary

Atlanta Cardiac Clinic
Grady Memorial Hospital
P. O. Box 3277
Atlanta, Georgia

J. Gordon Barrow, M.D.
Chief of Clinic

Mrs. Kathryn Starr
Clinic Secretary

Augusta Heart Clinic
University Hospital
Augusta, Georgia

Calhoun Witham, M.D.
Chief of Clinic

Mrs. Avery J. Beale
Clinic Secretary

Brunswick Heart Clinic
Glynn County Health Center
Brunswick, Georgia

Haywood L. Moore
Chief of Clinic

Mrs. Frances Andrews
Clinic Secretary

Columbus Heart Clinic
City-County Hospital
Columbus, Georgia

Jack M. Hirsch, M.D.
Chief of Clinic

Mrs. Kathleen Reddick
Clinic Secretary

Giddings Memorial Heart Clinic
St. Joseph's Infirmary
272 Courtland Street, N.E.
Atlanta, Georgia

T. Sterling Claiborne, M.D.
Chief of Clinic

Mrs. Miriam Minus
Clinic Secretary

Jesup Heart Clinic
Wayne County Health Center
Jesup, Georgia

Mrs. Alice P. Latham
Clinic Secretary

LaGrange Heart Clinic
City Hospital
LaGrange, Georgia

William B. Fackler, M.D.
Chief of Clinic

Macon Heart Clinic
City Hospital
Macon, Georgia

Allan A. Cole, M.D.
Chief of Clinic

Mrs. Frank Cary
Clinic Secretary

Savannah Heart Clinic
23 E. Charlton Street
Savannah, Georgia

Jean Williams Nichols, M.D.
Chief of Clinic

Mrs. Henrietta F. Mason
Clinic Secretary

Thomasville Heart Clinic
Thomasville, Georgia

Oscar M. Mims, M.D.
Chief of Clinic

Mrs. Delores Baisden
Clinic Secretary

Waycross Heart Clinic
Ware County Health Center
Waycross, Georgia

Arthur M. Knight, Jr., M.D.
Chief of Clinic

Miss Marie Carroll
Clinic Secretary



Brooke, M. M., Dorothy M. Melvin, Robert Sappenfield, Fred Payne, F. R. N. Carter, A. C. Offutt, and W. W. Frye, CDC, U. S. Dept. of Health, Education, and Welfare, Atlanta, Ga. "Studies of a Water-Borne Outbreak of Amebiasis, South Bend, Indiana," *AM. J. HYG.* 62:214-232 (Nov.) 1955.

Since 52.4 per cent of 1,542 employees in an industrial plant in South Bend had been found to harbor *Entamoeba histolytica*, a family contact study was conducted to determine the extent of familial spread of the infection. Stool specimens were collected from 600 contacts representing 334 families, preserved in formalin and polyvinyl alcohol (PVA)-fixative, and examined by formalin-ether concentration and permanent stained preparations. The prevalence rate for *E. histolytica* in family contacts was found to be 3.7 per cent, which was within the expected range for the area. There were no significant differences in the rates of *E. histolytica* in the contacts of positive and negative employees. It was concluded that no significant transmission of intestinal protozoa had taken place between employees and members of their families, probably because of relatively good sanitation within the homes.

Several factors of possible epidemiological significance were considered in the analysis of the data: city and rural residence, age and sex, family size, source of water, toilet facilities, and foodhandling. Interesting findings included: foodhandlers appeared to be unimportant in transmission of amoebae, and older males (40 to 60 years) had higher prevalence rates than the older females. It is suggested that in cities contamination of drinking water may be more frequent than is generally suspected and more important in transmission than foodhandling.

Wilkins, Sam A., Robert Winship Memorial Clinic, Emory Hospital, Emory University, Ga. "Immediate Reconstruction of the Cervical Esophagus: A New Method," *CANCER* 8:1189-1197 (Nov.-Dec.) 1955.

Reconstruction of the cervical esophagus after resection for carcinoma to permit swallowing has been and continues to be a major problem. Cures have been few, and usually by the time the gullet has been reestablished by a series of not-too-satisfactory plastic procedures recurrence of disease has become manifest. The clinical history and investigation relative to the problem are reviewed. Experience with a procedure in which the mucosal lining of the larynx and the anterior portion of the laryngeal cartilages are preserved and used to re-establish the gullet by anastomosis to the lower end of the esophagus is described. The application of this procedure is considered to be limited chiefly to lesions in the postcricoid area and to provide no advantage as to cure over other methods. The advantage, if it proves to exist, lies in the provision of better palliation measured in comfortable days for the patient while swallowing his diet. One patient is now

living and well 15 months after her operation, having swallowed her diet satisfactorily since the 24th post-operative day.

Galambos, John T., and Melvin I. Klayman, Emory University, Ga. "The Clinical Value of Colonic Exfoliative Cytology in the Diagnosis of Cancer Beyond the Reach of the Proctoscope," *SURG., GYNEC. & OBST.* 101: 673-679 (Dec.) 1955.

Colonic exfoliative cytology was performed on 68 patients during an 18-month period. All patients were suspected of having colonic lesions which could not be reached by the sigmoidoscope.

Two methods were used:

a. Twenty patients were examined by method I; nine of these were proven to have colonic carcinoma. Malignancy was correctly diagnosed in two cases by cytology and in six cases by conventional X-ray examination.

b. Forty-eight patients were examined by method II. Seventeen of these had proven colonic cancer. Malignancy was correctly diagnosed in 14 cases by cytology and in 15 cases by conventional X-ray examination (including repeated barium enemas).

Malignant cells were recovered in four of six cancers of the right colon; 11 of 19 cancers of the transverse and left colon. A metastatic ovarian carcinoma was correctly diagnosed.

In 32 patients colonic cancer was excluded. There were no false positive findings by cytology; in 17 of these 32 cases the benignancy was correctly diagnosed by X-ray.

In one patient colonic cancer was diagnosed by cytology using method II and by X-ray. This patient consented to surgery only after the printing of the article. She had a non-resectable carcinoma of the sigmoid.

Klayman, M. L., B. W. Massey, S. Pleticka, J. T. Galambos, L. Brandborg, J. B. Kirsner, and W. L. Palmer, Emory University, Ga. "The Cytologic Diagnosis of Gastric Cancer by Chymotrypsin Lavage I," *GASTROENTEROLOGY* 29:849 (Nov.) 1955.

A total of 313 symptomatic patients have been examined for gastric malignancy by the chymotrypsin lavage cytologic method. Sixty of 75 proved neoplasms were identified correctly. The causes of failure are discussed. Of 78 patients proved free of malignancy, 76 were diagnosed as benign, one as inconclusive, and one incorrectly as positive. One hundred sixty patients were observed clinically from six to 21 months after a negative cytologic examination in 157, and a positive report in three cases. Subsequent studies and the clinical course of the 157 patients corroborates the negative and suggests that the positive interpretation in three patients was false.* The cytologic finding in 12 partially gastrectomized patients is discussed.

*One of these three patients was operated upon since the completion of the original article. A large gastric carcinoma was found at surgery.

Dowman, Charles E., 1415 Peachtree St., N.E., Atlanta, Ga. "Diagnosis and Management of Brain Injuries," *AM. SURGEON* 21: 1127-1132 (Nov.) 1955.

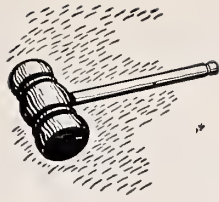
Head injuries fall into three categories. The first group, around 20 to 30 per cent, die early in spite of careful efforts. Fifty to 60 per cent of head injuries are cared for by the nurses, but it is quite important that the surgeon direct their care. Five to 10 per cent of head injuries will require some surgical operation to attack localized clots. The surgeon must assume primary responsibility in all patients to be sure he can select the small percentage requiring more active intervention. He must be well versed in nursing care in order that he may instruct and supervise available help in their efforts. Middle meningeal hemorrhage is the prime head injury emergency and should be recognized as soon as advancing unilateral neurologic signs are noted. It is better to do more trephines with negative findings than to find treatable hemorrhages in the morgue.

Hess, Melvin; Ira H. Slade, John C. Ammons, and Vernon Hendrix, Dept. of Anatomy, Emory University, Ga. "Pituitary ACTH Content of Thyroidectomized Rats," *AM. J. PHYSIOL.* 183:261-262 (Nov.), 1955.

Pituitary glands of thyroidectomized and intact rats were assayed for ACTH content with and without the application of a stress. The depletion of ACTH from the pituitaries of stressed thyroidectomized rats was no greater than that of similarly treated intact animals. The adrenal glands of operated-stressed animals, however, revealed an increased response to the released ACTH, as evidenced by greater depletions of ascorbic acid, compared to intact-stressed rats. The data indicate a hypersensitivity of the adrenal of the thyroidectomized rat to a given amount of ACTH above the "resting" physiological level.

Wolcott, Mark W., and Harry E. Walkup, VA Hospital, Forest Hills Division, Augusta, Ga. "Surgical Treatment of Bullous Emphysema," *DIS. OF CHEST* 28:638-650 (Dec.) 1955.

Bullous emphysema is divided into Type 1, localized disease restricted to one segment or one lobe, and Type 2, generalized disease with several segments involved and with an element of hypertrophic emphysema of the remaining lung tissue. Evaluation of the patient is discussed in the light of degree of involvement, degree of infirmity, and associated conditions. Careful evaluation is stressed. Surgery consisting of excision of the large bullae with control of air leaks by individual closure of open bronchioles and pleuralization where possible is the surgical method of treatment preferred. The results from excisional surgery for emphysematous bullae have been most gratifying. Ninety-five per cent of a series of 16 cases obtained some degree of improvement following operation. It is important to remember that cure is not sought but that a marked degree of improvement may restore a patient to a useful life, even though on a restricted basis.



president's page

THIS PAGE FINDS MY TENURE as President rapidly drawing to a close and not without some sense of relief. Efforts to attend meetings of the Council, the Executive Committee of Council, special activities of standing committees, district society meetings, and two county society meetings celebrating a half century of organization have kept me much on the go and always with an accumulation of work with each return home. With all of this there has still been much activity of the Association that I have had to neglect even in spite of the very industrious headquarters force's attempt to keep me currently informed.

All standing committees are accepting their duties seriously, and I want to commend every effort being made by these committees to improve and extend competent medical practice and recommend that every MAG member read these committee reports as they are published first in the *Delegates' Handbook* and later in the *Journal*.

The Legislative and Public Relations Committees are working our assistant executive secretary most effectually, and the chairmen of these committees are not sparingly giving of their own time and travel in personal directions. With dignity and conciseness, order is coming rapidly into these two important fields. The Mental Health, Maternal and Infant Welfare, Insurance, and Civil Defense Committees are also following closely integrated programs. A most important committee that I should be better acquainted with is the Hospital Relations Committee as now separated from education. This committee will have the greatest responsibility and opportunity for service to organized medicine if our proposed legislation as to a Medical Commission on Hospital Care for Indigents has been acted upon favorably by the legislature and the Governor.

H. D. Allen, Jr.

New Members

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Charles Emory Bohler	Box 115, Brooklet	Active	Bulloch-Candler-Evans
John W. Acree	Hiawassee	Active	Habersham
Fred Otto Kessler, Jr.	802 Abercorn St., Savannah	Active	Georgia Medical Soc'y
B. H. Cogdell	Nicholls	Active	Coffee
Will Henry Aufranc	DHEW Reg. IV. 50 Seventh St., N.E., Atlanta	Service	Fulton
Milton F. Bryant, Jr.	1211 W. Peachtree, N.E., Atlanta	Active	Fulton
Marvin L. Davis	Buckhead Professional Bldg. 3158 Maple Dr., N.E., Atlanta	Active	Fulton
Noble Owen Fowler	69 Butler St., S.E., Atlanta	Active	Fulton
Catherine E. Foster	272 Courtland St., Atlanta	Associate	Fulton
Sidney Z. Gellman	622 W. 168 St., New York	Active	Fulton
John Thomas Godwin	265 Ivy St., N.E., Atlanta	Active	Fulton
Joseph A. Hertell	230 Spring St., N.W., Atlanta	Service	Fulton
James A. Langford	Roswell	Active	Fulton
William McKee Madison, Jr.	Emory Univ. Clinic Emory University	Associate	Fulton
Sanford John Matthews	1293 Peachtree St., N.E., Atlanta	Active	Fulton
Nathaniel Albert Thornton	Baptist Professional Bldg. 340 Blvd., N.E., Atlanta	Active	Fulton
David S. Sowell	Cotton Road, Pelham	Active	Mitchell
Meynard Ihnen	Laboratory, Univ. Hosp. Augusta	Active	Richmond
Atwood M. Freeman, Jr.	Univ. Hosp., Augusta	Associate	Richmond
Charles Martin Rhode	VA Hosp., Augusta	Active	Richmond
Harold Frederick Lindsey	Hahira	Active	South Georgia
Jackson Wiley Landham, Jr.	217 S. 8th St., Griffin	Active	Spalding
Albert R. Howard	Jesup	Active	Wayne

Law Governing the Practice of Nursing in Georgia

IT IS AGAIN TIME for all registered nurses to renew their registrations for 1956 in the State of Georgia. The Board of Examiners of Nurses for Georgia is anxious to reach as many nurses as possible and those employed in doctor's offices is one of the hardest groups to contact. The following information is printed in the *Journal of the Medical Association of Georgia*, in the hope it might reach many of this group:

"SECTION 84-9915—It is unlawful for any person or persons to practice professional nursing as a graduate nurse or registered nurse without a certificate from the Board of Examiners of Nurses for

Georgia; and any person violating any of the provisions of Chapter 84-10 shall be guilty of a misdemeanor . . ."

To work in the state of Georgia as a graduate or registered nurse it is necessary to obtain a certificate of registration or a temporary permit. This certificate of registration must be renewed annually. Applications for interstate licensure can be obtained from the Board of Examiners of Nurses for Georgia, 116 Mitchell St., S. W., Atlanta 3, Georgia. Annual renewal fees are payable at this address on or before February 28th of each year.

ANNOUNCEMENTS

American Congress of Physical Medicine and Rehabilitation Annual Prize Lecture—Prize for an essay on any subject relating to physical medicine and rehabilitation. Primarily directed to medical students, interns, residents, and graduate students. Manuscripts must be in the office of the ACPMR, 30 North Michigan Ave., Chicago 2, Ill., not later than June 1, 1956. Manuscripts must not exceed 3000 words and the number of words should be stated on title page. Winner receives a cash award of \$200, a gold medal, certificate, and invitation to present the contribution at the 34th Annual Session of the Congress, September 9-14, 1956, at the Ambassador, Atlantic City, N. J. For further information, write to the executive secretary, Dorothea C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Ave., Chicago 2, Ill.

New York University Post-Graduate Medical School Courses—Feb. 27-29, Auscultation of the Heart; March 1 and 2, Cardiac Roentgenology; March 19-23, Electrocardiography, stressing the basic electrophysiology of the heart; March 23, Cardiac Arrest and Resuscitation; March 19-24, Surgery of the Hand; March 5-10, or March 12-16 (two sessions), Motor Anomalies of the Eye; March 19-24, Surgery of the Eye; March 5-10, Review of Clinical Pediatrics; March 12-16 and June 4-8, Symposium on Tuberculosis and other Pulmonary Diseases of Childhood. For further information, write to Robert Sheffield, N.Y.U.-Bellevue Medical Center, New York City.

American Cancer Society 3rd National Cancer Conference—Sheraton-Cadillac Hotel, Detroit, Mich., June 4, 5, and 6, 1956. Morning and afternoon sessions will begin with a general session with an outstanding speaker; the general sessions will break into various symposia to discuss cancer of different body sites. Copies of the program and advance registration cards may be obtained from the National Cancer Conference Coordinator, American Cancer Society, 521 West 57th St., New York 19, N. Y.

Fifth Congress of Pan American Medical Women's Alliance—Santiago and Vina del Mar, Chile, March 6 to 14, 1956. Opportunities for sightseeing and visits to medical programs in Mexico, Salvador, Panama, Chile, Bolivia, and Peru have been arranged. Information may be obtained from the secretary, Dr. Eva F. Dodge, 2124 West 11th Street, Little Rock, Ark., or from the program chairman, Dr. Eva Cutright, Wooster, Ohio.

First International Symposium on Venereal Diseases and the Treponematoses—Statler Hotel, Washington, D. C., May 28-June 1, 1956. Sponsored by the U. S. Dept. of Health, Education, and Welfare, and the World Health Organization. The symposium is open to all physicians, scientists, and professional health workers interested in participating. Anyone interested in submitting a paper for consideration by the program committee should send an abstract of his paper to Dr. C. A. Smith, Medical Director, Chief, Venereal Disease Program, Division of Special Health Services, Public Health Service, Dept. of Health, Education and Welfare, Washington 25, D. C. before February 1, 1956.

Pan American Medical Association 10th Inter-American Congress—April 15-21, 1957, Mexico City. For information write to Dr. Joseph J. Eller, 745 Fifth Ave., New York, N. Y.

American Trudeau Society Post-graduate Course in Pulmonary Function—Boston, March 26-30, 1956. Methods of analysis of pulmonary function and related cardiac function will be described and demonstrated. Tuition: \$50.00. Applications and information may be obtained from Edward J. Welch, M.D., 1101 Beacon St., Brookline 46, Mass.

Gill Memorial Eye, Ear, Nose and Throat Hospital 29th Annual Spring Congress in Ophthalmology, Otology, Rhinology, Laryngology, Facio-Maxillary Surgery, Bronchoscopy, Esophagoscopy—Roanoke, Va., April 2-7, 1956. Tuition: \$75 or \$40 for half the session. For information write to Dr. E. G. Gill, Box 1789, Roanoke, Va.

International Academy of Proctology 8th Annual Convention—Drake Hotel, Chicago, April 23-26, 1956. For details write to Dr. Alfred J. Cantor, Secretary, International Academy of Proctology, 147-41 Sanford Ave., Flushing 55, N. Y.

Hawaii Medical Association Centennial Celebration and Scientific Congress—Honolulu, April 22 to 29, 1956. Every physician in the U. S. is invited to celebrate the centennial with the Hawaii Medical Association. There will be a short but worthwhile professional program on Monday and Tuesday mornings, Centennial Celebration Pageant Tuesday night, and a traditional luau (Hawaiian feast) Thursday night, with Polynesian entertainment. Tours are planned for each day of the meeting. For information and reservations write to the Hawaii Medical Association, 510 South Beretania St., Honolulu 13, Hawaii.

Medical Officers, U. S. Public Health Service Regular Corps Examinations—Competitive examination for appointments will be held throughout the country on March 20, 21 and 22, 1956. Entrance pay for Assistant Surgeon with dependents is \$6,017 per year; for Senior Assistant Surgeon with dependents, \$6,918. Application forms may be obtained from the Chief, Division of Personnel, Public Health Service, Dept. of Health, Education, and Welfare, Washington 25, D. C. Completed application forms must be received in the Division of Personnel no later than February 10, 1956.

American College of Allergists Graduate Instructional Course and 12th Annual Meeting—Hotel New Yorker, New York City, April 15-17, 1956 (Course) and April 18-20, 1956 (Meeting). For further information write to Dr. Fred W. Wittich, Secretary-treasurer, American College of Allergists, Inc., 401 LaSalle Bldg., Minneapolis 2, Minn.

DEATHS

JOHN WILSON GOOD, Cedartown, died December 19, 1955, at the age of 77.

Dr. Good was the oldest physician in Polk County and had practiced medicine in the county since 1900. He was twice mayor of Cedartown, on the city council four years, and

was serving his second four-year term on the county commission. In 1953 he was appointed by Governor Herman Talmadge to represent Georgia at the First Western Hemisphere World Medical Conference held in Richmond, Va.

Dr. Good was born on a farm eight miles north of Cartersville; he graduated from the University of Tennessee Medical College in 1898 and interned for two years in Nashville, Tenn. He was a member of Caledonia Lodge 121, Masons, and the Royal Arch, Commandry and Yaarab Shrine Temple.

Funeral services were held at the First Presbyterian Church, of which he was a member and elder for many years, on December 21, 1955.

Immediate survivors include his wife, the former Miss Lois Bedwell, and two sons, Mr. John Good of Baltimore, Md., and Mr. Edward Good of Dallas, Texas.

HOWELL PARKS HOLBROOK, JR., Tucker, died of a heart attack on January 14, 1956, at the age of 32.

A graduate of the University of Georgia and the Medical College of Georgia at Augusta, he had practiced in Tucker for the past four years. He served for three years in the Air Force before going to Tucker. Dr. Holbrook was a native of Commerce.

A member of the DeKalb County Medical Society, Dr. Holbrook was also a steward of the Tucker Methodist Church.

Survivors include his wife, the former Miss Nell Bennett, daughter of Dr. and Mrs. V. H. Bennett of Gay; his mother, Mrs. Park Holbrook of Commerce; a brother, Col. Thomas H. Holbrook of Washington, D. C.; and a sister, Mrs. Thomas L. Downey of Atlanta. Funeral services were held on January 16, 1956, in Commerce.

HENRY GRADY LEE, Millen, died in an Augusta hospital on December 26, 1955. He was 65 years old at the time of his death.

Born in Screven County, he had practiced medicine in Millen for about 30 years. He was a graduate of the Medical College of Georgia and had practiced in Woodcliff before going to Millen.

Dr. Lee was a member of the Screven Masonic Lodge and the Alee Temple Shrine, a charter member and former president of the Millen Rotary Club, a member of the Board

of the Jenkins County Health Center, a director in the Planters Electric Membership Corp., and a member of the Millen Baptist Church.

Surviving are his wife, the former Miss Esther Thompson of Vidalia; a daughter, Mrs. Robert Reeves, Millen; a granddaughter; and his mother, Mrs. W. D. Lee of Sylvania.

Funeral services were conducted at the Millen Baptist Church on December 28, 1955.

J. M. MCKENZIE, Thomaston, died in his eightieth year on January 2, 1956. He had practiced medicine in Upson County for 53 years.

Dr. McKenzie was a native of Upson County, born there on February 9, 1877. He attended Robert E. Lee Institute and the Medical College of Georgia. He transferred to Atlanta and is a graduate of what is now known as Emory University School of Medicine. He served as county physician for more than 25 years and had been recognized for a quarter of a century of service as a Central of Georgia railroad surgeon.

When Dr. and Mrs. McKenzie returned from a trip to Europe last September the whole of Thomaston turned out to honor him on "Dr. McKenzie Day." Public ceremonies were held on the courthouse square, and hundreds of the now grown babies he had delivered sent postcards which were compiled in a scrapbook which was presented to him on "Dr. McKenzie Day."

He is survived by his wife, the former Miss May Belle Dixon; three daughters and a sister.

Funeral services were held on January 4, 1956, at the First Methodist Church; interment was in Glenwood Cemetery.

JOHN JUDSON PILCHER, Wrens, died on January 14, 1956, in an Augusta hospital. He was 64 years old.

Dr. Pilcher was born in Stellaville, the son of the late Dr. and Mrs. James Wright Pilcher. He was graduated from Mercer University and the Medical College of Georgia. Dr. Pilcher had far-reaching business interests and was active in the Boy Scout movement. He was long active in the civic, religious, business, and political life of Wrens and Jefferson County. At the time of his death he was mayor of Wrens. He was a member of the Jefferson County Medical Society and a former member of the board of trustees of Mercer University.

Funeral services were held on January 15, 1956, at the Wrens Baptist Church.

Surviving him are his wife, the former Miss Marian Kelley; four sons, three of whom are doctors, James W. Pilcher, George Pilcher, and John J. Pilcher, Jr., and Mr. Wallace Pilcher.

O. L. ROGERS, Sandersville, died at the age of 81 on January 10, 1956, in Sandersville. Dr. Rogers had been ill for quite some time.

Funeral services were held on January 11, 1956, at the Methodist Church of Sandersville, with burial in Brownwood Cemetery. Members of the Washington County Medical Society served as honorary pallbearers.

Dr. Rogers attended Mercer University and the University of Georgia; he received his M.D. degree from the University of Maryland. He had practiced in Sandersville for 55 years and for the past 20 years was county health commissioner. He was the oldest living member of Kappa Sigma Fraternity, member of the Washington County Medical Society, and senior surgeon at Rawlings Sanatorium, which he helped the late Dr. William Rawlings establish 50 years ago. He was a life member of the Medical Association of Georgia.

ROBERT E. STEGALL, Moultrie, died on January 14, 1956, at the age of 44. Funeral services were held on January 16th at the First Presbyterian Church; burial was in Westview Cemetery, Moultrie.

With the exception of four years active service with the Medical Corps of the U. S. Air Force during World War II, Dr. Stegall had practiced medicine and surgery in Moultrie since July 1938. Dr. Stegall was born in Gulfport, Miss.; he attended the University of Mississippi and received his M.D. degree from Emory University School of Medicine. He interned at Grady Hospital in Atlanta.

Dr. Stegall was a member and past president of the Colquitt County Medical Society. He served as chairman of the board of deacons in the Presbyterian Church and was elected an elder in the church only a week before his death.

Surviving are his wife, the former Miss Helen Miller; three children, Susan, Robert Miller, and John Edward Stegall, II; and his mother, Mrs. J. E. Stegall, Gulfport, Miss.

SOCIETIES

New officers of the DEKALB COUNTY MEDICAL SOCIETY for the year 1956 are Fincher C. Powell, Decatur, president; John T. Leslie, vice-president, and William K. Kerr, secretary-treasurer. Delegates to the Medical Association of Georgia are W. A. Mendenhall and Freeman Simmons. Their alternates are G. L. Mitchell and L. C. Buchanan. Dr. Powell is a former secretary-treasurer of the society, and he succeeds Dr. Simmons in the office of president.

At the December meeting of the ELBERT COUNTY MEDICAL SOCIETY, which was held at the Elberton-Elbert County Hospital, Phyllis J. O'Neal, Elberton, was installed as president of the society. A. S. Johnson, Jr., was elected president-elect, and Carey A. Mickel, Jr., was re-elected secretary-treasurer. Fletcher Smith is a carry-over censor, D. V. Bailey was appointed to a two year term as censor, and D. N. Thompson to a three year term. Dr. O'Neal is the first woman to practice medicine in Elbert County and as such is the first woman to serve as president of the Elbert County Medical Society.

At a recent meeting of the EMANUEL COUNTY MEDICAL SOCIETY H. Wilder Smith, Swainsboro, was elected president for the year 1956. Dr. Smith is also chief-of-staff of the Emanuel County Hospital. Dr. Smith is a graduate of the University of Georgia and the Medical College of Georgia; he has been in practice in Swainsboro since 1948, with the exception of time spent in the armed forces during the Korean conflict.

The FULTON COUNTY MEDICAL SOCIETY held its annual business meeting at the Atlanta Athletic Club on January 5, 1956. McLaren Johnson was installed as president of the society; Don F. Cathcart is the new president-elect. Other officers include Edgar Boling, vice-president, Charles S. Jones, judicial counselor, Cyrus W. Strickler, Jr., senior board of trustees member, and J. Frank Walker, junior board member. Rives Chalmers, Atlanta, was presented the second annual Aven Citizenship Cup for his outstanding service in community affairs. Dr. Chalmers served as chairman of the health section, Metropolitan Atlanta Community Services; on the Chamber of Commerce health committee, as a member of the board of the National Mental Health Association. Mr.

Ernest Rogers, of *The Atlanta Journal*, was the guest speaker for the meeting.

New officers of the GEORGIA MEDICAL SOCIETY are Ruskin King, Savannah, president; Walter E. Brown, president-elect; William H. Fulmer, vice-president; W. W. Osborne, secretary, and Ralph O. Bowden, treasurer. These officers were elected at the December meeting of the society. The January meeting of the society was held on January 10th at 612 Drayton St., Savannah. Farnum Coffin presented a paper on "Some Practical Aspects of Hematology."

Mack Simmons, St. Simons Island, was elected president of the GLYNN COUNTY MEDICAL SOCIETY at the December meeting, succeeding Robert S. Burford. John Hightower, Brunswick, was elected vice-president; James M. Hicks, Brunswick, was re-elected secretary-treasurer; and Frank B. Mitchell, Brunswick, was named assistant secretary.

B. A. McCrum, Gainesville, has been installed as president of the HALL COUNTY MEDICAL SOCIETY, succeeding Cullen McCarver. Other new officers for 1956 are as follows: Martin Smith, vice-president; Hamil Murray, secretary-treasurer; and P. K. Dixon and Rafe Banks, delegates. These officers were elected at the January meeting of the society, at which time the members also heard an address by Fleming Jolley, Atlanta neurosurgeon.

The MUSCOGEE COUNTY MEDICAL SOCIETY held its January meeting at the Standard Club on January 24, 1956. William G. Hamm, Atlanta, was guest speaker at this meeting. Dr. Hamm is former chairman of the American Board of Plastic Surgery and president of the American Society of Plastic and Reconstructive Surgery.

The THOMAS-BROOKS MEDICAL SOCIETY held its regular Christmas meeting on December 16, 1955, in Thomasville. The scientific program featured talks by Ralph Sapuenfield, director of the department of anesthesia at Jackson Memorial Hospital in Miami, and George Harrell, dean and professor of medicine at the University of Florida Medical School in Gainesville. Following the meeting the society held a banquet and dance at the Glen Arven Country Club. Special guests were members of the Council of the MAG and their wives.

The TIFT COUNTY MEDICAL SOCIETY was entertained by C. S. Pittman, Sr., at his home in December. Dr. Pittman presided at the business meeting at which time Tom Edmondson was elected president of the society; R. E. Jones, vice-president; and Paul Lucas, secretary and treasurer. A buffet dinner followed the business meeting.

The WALTON COUNTY MEDICAL SOCIETY has named Ralph E. Wenzel, Social Circle, its president for the year 1956. Homer Head, Monroe, is vice-president, and Ernest Thompson, Monroe, was re-elected secretary. C. S. Floyd, Loganville, was elected delegate to the MAG House of Delegates, with Lynn M. Huie, alternate delegate.

PERSONALS

First District

Heads of the various departments of the Warren A. Candler Hospital medical staff were elected on January 3, 1956, at a meeting at the hospital. The chiefs of the departments are the following Savannah physicians: JOHN L. ELLIOTT, medicine; OSCAR H. LOTT, surgery; DARNELL L. BRAWNER, obstetrics and gynecology, and W. A. COLE, radiology.

JOHN L. ELLIOTT, Savannah, has been elected president of the Physicians Service Association of Savannah. He succeeds RALPH O. BOWDEN, who has headed the association since its organization in 1951. New directors named include ROBERT B. GOTTSHALK, L. M. FRIEDMAN, WILLIAM H. LIPPITT, and JOHN SHARPLEY.

L. F. LOVETT and his wife, KATHRYN SIMMONS LOVETT, Metter, have moved to Augusta where he is serving a residency in surgery and she is a resident in psychiatry at the VA hospital. Both physicians have been practicing medicine in Metter for several years in the office with W. E. SIMMONS, father of Kathryn Lovett.

C. R. A. REDMOND, Savannah, has been elected president of the medical staff of Warren A. Candler Hospital for 1956. DAVID ROBINSON was elected vice-president, and FENWICK T. NICHOLS, JR., secretary-treasurer.

Second District

MARK W. FOWLER, Albany, was the guest speaker at a recent meeting of the Albany Civitan Club. Dr.

Fowler spent seven years is a missionary in South and Central Africa, and has just recently come to Albany to practice medicine. He showed color slides and answered questions concerning the customs, economics, religions, and languages of the peoples pictured. Of particular interest was the description of the treatment of leprosy and the establishment of leper colonies in Africa.

JOHN S. INMAN JR., Albany, has been made a fellow of the American Academy of Obstetrics and Gynecology.

PHIL E. ROBERSON, Albany, has been re-elected chief of the medical staff of Phoebe Putney Memorial Hospital for 1956.

Third District

HENRY R. FENN, Americus, has been elected president of the staff at the Americus and Sumter County Hospital. Also named to serve with him were FRANK A. WILSON, III, vice president, and W. R. ANDERSON, secretary.

A commendation ribbon for meritorious service has been awarded to DANIEL E. NATHAN, Ft. Valley, a flight surgeon and general surgeon in the U.S.A.F. Reserve with the rank of lieutenant colonel. Dr. Nathan is a native of Savannah, a graduate of the University of Georgia and the Medical College of Georgia. The Ft. Valley physician was commended for distinguishing himself by meritorious service to the U. S. Air Force while assigned to Warner Robins Air Materiel Area for training as general surgeon with the 2795th U.S.A.F. Hospital at Robins AFB from 1953 through 1955.

Fourth District

GEORGE L. WALKER, Griffin, was the speaker at a recent meeting of the Griffin Kiwanis Club. He discussed the relationship of obesity to heart disease, concluding that according to past experience and records overweight people are much more likely to be victims of heart disease than are thin people.

Governor Marvin Griffin has appointed VIRGIL B. WILLIAMS, Griffin, to the State Board of Health. He was sworn in on January 18, 1956, to serve until September 1, 1961.

Fifth District

C. RAYMOND ARP, Atlanta, has been appointed instructor in medicine at Emory University School of

Medicine. Dr. ARP will be at Emory only part-time; his office in Suite 207, Doctors Building, 478 Peachtree St., N.E., where he specializes in internal medicine and allergy.

MURDOCK EQUEN, Atlanta, was one of the panelists in a discussion on "Surgery of the Larynx" held in Philadelphia on February 15 during the meeting of the American College of Surgeons. It has also been announced that Dr. Equen will be on the program of the A.M.A. Convention to be held in Chicago June 12-14, 1956. His paper will be on "Nail in Duodenum Removed with Magnet."

J. HIRAM KITE, Atlanta, spoke at the 122nd meeting of the American Association for the Advancement of Science which was held in Atlanta in December. Dr. Kite told the members assembled that crippling from osteomyelitis is fast becoming a medical rarity, thanks to the wonder drugs. Dr. Kite is chief surgeon of the Scottish Rite Hospital for Crippled Children, Decatur. He said that when the Scottish Rite Hospital was founded in 1915 osteomyelitis was causing more deaths than all other bone-and-joint diseases combined. In 1954, only two children were admitted with osteomyelitis; the discovery of the sulfonamides and penicillin has changed this from a surgical condition to a medical problem. Bone destruction has been prevented by early treatment.

TED F. LEIGH, EDGAR F. FINCHER, and MAXWELL F. HALL, JR., Atlanta, all members of the faculty of the Emory University School of Medicine, won a high award at the annual meeting of the Radiological Society of North America in Chicago in December for their exhibit entitled "Routine Skull Films in Intracranial Meningiomas." The award, a Certificate of Merit, was the second highest award given in the category of Clinical Research.

HAROLD B. LEVIN, Atlanta was the guest speaker at the January meeting of the Cobb County Medical Society held at Kennestone Hospital.—"The Modern Management of Common Dermatological Problems" was the subject of discussion.

Speaking at a recent meeting of the Georgia Heart Association Board of Directors JOSEPH C. MASSEE, At-

lanta, chairman of the vocational rehabilitation committee of the association, emphasized the fact that work is good for cardiac patients in most cases—but Georgia law as now interpreted discourages employers from hiring persons with heart disease. Also speaking on this subject were JEFF RICHARDSON, Atlanta, and EUGENE B. FERRIS, Atlanta. RICHARD W. BLUMBERG, Atlanta, chairman of the rheumatic fever committee of the Georgia Heart Association, reported that Georgia's "Stop Rheumatic Fever" Program must be a continuous educational program to be effective.

SANFORD J. MATTHEWS, Atlanta, has been appointed Associate Medical Director of the Henrietta Eggleston Hospital for Children, Atlanta. M. H. ROBERTS, Atlanta, is the Medical Director.

NEIL T. PERKINSON, Atlanta, announces the opening of his office for diagnosis and treatment of neoplastic diseases at Suite 610 Doctors Bldg., 384 Peachtree St., N.E., Atlanta. Dr. PERKINSON is a graduate of Emory University and the Bowman-Gray School of Medicine, Winston-Salem, N. C. He interned at Bellevue Hospital in New York City before spending two years in the U. S. Navy. He spent a year as assistant resident in pathology; a year as assistant resident in surgery at the Roosevelt Hospital in New York; a year as assistant resident in surgery at St. Luke's Hospital, New York; and three and a half years as assistant resident, resident, and fellow at the Memorial Center for Cancer and Allied Diseases in New York City. Dr. PERKINSON is a native of Marietta, the son of W. H. PERKINSON; he is married and has three children. A member of the Chi Phi social fraternity, Phi Rho Sigma medical fraternity, Dr. PERKINSON is also a diplomate of the American Board of Surgery.

FINCHER C. POWELL and CHESTER W. MORSE, Decatur, have been appointed to the medical branch of the Metropolitan Atlanta Area Civil Defense unit. Also serving in this unit are LAMAR B. PEACOCK, Atlanta, chief; A. HAMBLIN LETTON, Atlanta, chief of the casualty section; STEWART LONG, Atlanta, chief of the emergency care section, and WILLIAM CROWE, Atlanta, representative for the north zone.

IVAN B. ROSS, Atlanta, has been appointed pathologist and laboratory

director of the Griffin-Spalding County Hospital. He will direct the lab work including the examination of tissue which in the past has been sent to other hospitals for analysis and examination. Dr. Ross will also serve as pathologist for the Upson County Hospital in Thomaston, but he will make his home in Griffin. A native of Vermont, Dr. Ross is a graduate of the University of Vermont Medical School. He received his training in pathology at Crawford W. Long Memorial Hospital in Atlanta, and for the past six years has been director of pathology at Georgia Baptist Hospital in Atlanta.

Dr. and Mrs. LESTER RUMBLE, JR., Atlanta, announce the birth of a son, Anthony Lester, on January 14, 1956.

T. F. SELLERS, Atlanta, director of the Georgia Department of Public Health, has been elected president of the State and Provincial Health Authorities of North America. This organization was set up in 1884 to consider public health problems found on the North American Continent. Dr. Sellers is the second Georgian to hold the office of president. The first was T. F. ABERCROMBIE, former director of the Georgia Department of Public Health, who was elected to the office in 1935.

S. ANGIER WILLS, Atlanta, has won a prize round-trip ticket for two to Los Angeles in a contest sponsored by the TV program "You Asked For It." Dr. Wills, resident surgeon at Grady Memorial Hospital, was married to Miss Jan Jo Coarsey on January 7th, and they went to Los Angeles for four days on their honeymoon.

Changes in the administration of the Emory University School of Medicine were announced on January 20th by the University's president. R. HUGH WOOD, for the past 10 years dean of the medical school and director of the Emory University Clinic, will devote full time to his work as clinic director. Arthur P. Richardson, director of the division of basic health sciences, will become dean of the medical school; and Carl C. Pfeiffer, chairman of the department of pharmacology, will become acting director of the division of basic health sciences. The changes will be effective July 1, 1956, according to the announcement.

Sixth District

J. FRANK JOHNSON, Macon, was one of the participants in a panel discussion on medical ethics held at the Medical College of Georgia in Augusta on January 6th. Dr. Johnson discussed "Telling the Truth to Patients."

A. M. PHILLIPS, Macon, has been elected president of the executive committee and the staff of Parkview Hospital for 1956. JOSEPH W. DANIEL, JR., was elected secretary of the staff and was also named to the committee. Other committee members include W. DEVEREAUX JARRATT, O. F. KEEN, J. L. KING, SAMUEL E. PATTON, and E. C. McMILLAN. W. W. BAXLEY is the outgoing president.

J. BENHAM STEWART, director of the Macon Cancer Clinic, spoke at a recent meeting of the Barnesville Rotary Club; he told of Georgia's preeminence in the field of state aid for the treatment of cancer. Dr. Stewart was introduced by JOHN CRAWFORD, Barnesville.

E. Y. WALKER, Milledgeville, has been made a fellow of the American Academy of Obstetrics and Gynecology.

Seventh District

TOM HARBIN, Rome, is the new president of the Rome and Floyd County YMCA. Dr. Harbin is a graduate of Emory University and Cornell University Medical School and specializes in diseases of the eye, ear, nose, and throat at the Harbin Clinic in Rome.

W. HARVEY HOWELL, Cartersville, spoke at a recent meeting of the Cartersville Rotary Club on the lethal powers of bacteria.

James H. Jenkins, Rome, has joined the staff of the Harbin Clinic as a specialist in obstetrics and gynecology. Originally from Texas, Dr. Jenkins comes to Rome from Denver. He is a graduate of the University of Texas and Johns Hopkins School of Medicine. His internship and two years' residency were served at Johns Hopkins Hospital. Dr. Jenkins served nine years in the U. S. Army, attaining the rank of lieutenant colonel.

VIRGINIA HAMILTON MALEY, formerly of Gainesville, has gone to Cartersville to assume her duties as commissioner of health for Bartow, Gordon, and Cherokee Counties. Dr. Maley is a graduate of the Univer-

sity of Alabama and the Medical College of Alabama. For the past five years she has been commissioner of Health for Hall and Banks Counties.

Eighth District

ERWIN R. JENNINGS, Brunswick, has been named 1955 Man of the Year in Brunswick where he has been in practice for about two years. The selection was made by the local Jaycees.

ALTON M. JOHNSON, Valdosta, has been made president of the staff of Pineview General Hospital in Valdosta. R. K. WINSTON is vice-president, and F. G. ELDRIDGE is secretary.

J. A. LEAPHART, Jesup, has closed his 72-bed hospital in Jesup because of his health and incidental reasons. The hospital will probably be leased temporarily to the county. Dr. Leaphart has bought a home on Sea Island, located at Ribault Lane and 28th Street.

CLAYTON M. MASSEY, Waycross, was guest speaker at the January meeting of the Gilchrist Park School P.-T.A. He addressed the group on "Your Child's Health."

Roy F. Thagard, Brunswick, has announced the opening of an office in the Andrews Building, 509½ Gloucester St., for the practice of pediatrics. A native of Andalusia, Ala., Dr. Thagard is a graduate of Vanderbilt University and Vanderbilt Medical School. He interned at the University of Virginia Hospital, Charlottesville, and was resident in pediatrics at the Medical College of Virginia Hospital in Richmond. Dr. Thagard practiced in Anniston, Ala., before he entered the Army. Dr. and Mrs. Thagard were in Andalusia for eight months before coming to Brunswick.

PAUL H. WILSON, formerly of Thomson, has opened his office in Alma for the general practice of medicine and surgery. His office is in the Johnson Drug Building. A native of Waycross, Dr. Wilson is a graduate of the University of Georgia and the Medical College of Georgia. He received postgraduate training at the Spartanburg General Hospital in South Carolina. He practiced medicine in Thomson for four years prior to going to Alma.

Ninth District

JOHN K. BURNS, III, and BEN NALLEY, Gainesville, announce their as-

sociation in the practice of obstetrics and gynecology with offices located in the new building on Mountain Street, adjacent to the Hall County Hospital. Both physicians are natives of Gainesville; Dr. Burns practiced with his father, J. K. BURNS, JR., before the new building was completed about February 1st, and Dr. Nalley will begin his practice in July after completing his present training at Johns Hopkins Hospital in Baltimore. Dr. Nalley has been in Baltimore for the past two and a half years. He has been on the staff of the Hall County Hospital since 1951, and was president of the Hall County Medical Society in 1952. Dr. Nalley is a graduate of Emory University and Emory University School of Medicine. Dr. Burns has just completed three years residency in obstetrics and gynecology at Crawford W. Long Memorial Hospital in Atlanta. He is a graduate of Davidson College and the Medical College of Georgia. Dr. Burns first practiced in Gainesville in 1948. He served in the U. S. Navy during the Korean War, and went to Crawford Long Hospital upon completion of his tour of duty.

J. R. CHASTAIN, who has been practicing medicine in Buford for the last 15 years, has accepted a position of medical director of the Pacolet Mills clinic of New Holland, just outside Gainesville. Dr. Chastain will also continue to practice privately.

JOHN O. HOUSE, Gainesville, formerly director of anesthesiology at the Georgia Baptist Hospital in Atlanta, has joined the staff of the Hall County Hospital as director of anesthesiology.

HARRY HUTCHINS and W. J. HUTCHINS, Buford, have moved into the new Doctors Building adjoining the Hutchins Memorial Hospital on Scott Street. Prior to this move, the

physicians had their offices in the hospital.

ROBERT E. SHIFLET, Toccoa, who previously announced that he would leave Toccoa to join the staff of the Medical College of Georgia, has announced that he will remain in Toccoa. His office is on North Sage Street.

J. G. WOODWARD, Dahlonega, was to have reported for duty with the U. S. Army on January 4, 1956, but his orders were revoked. He will remain in practice in Dahlonega indefinitely.

Tenth District

JOHN L. BARNER, Athens, director of the Athens Cancer Clinic, was the principal speaker at a joint meeting of the Lavonia and Carnesville Lions Clubs in January. The meeting was held in Lavonia, and more than 100 people attended.

ROBERT B. GREENBLATT, Augusta, has been named winner of the Phi Lambda Kappa Scientific Award. The national Jewish medical fraternity presented the award at the final session of its convention in Atlantic City. He was cited for his scholarship, research and scientific literature concerning the endocrine glands. The award is given to the Jewish physician who in the opinion of the award committee has contributed most to the advancement of the medical sciences.

LOUIS O. J. MANGANIELLO, Augusta, was one of the participants in the three-day sectional meeting of the American College of Surgeons, January 16-18, at Jacksonville, Fla. Dr. Manganiello conducted a symposium on trauma.

D. F. MULLINS, JR., Augusta, was guest speaker at a recent staff meeting of the Laurens County Hospital. Dr. Mullins is pathologist for the hospital. He held a clinicopathological conference and declared that the percentage of accuracy of diag-

noses in the Laurens County Hospital in surgical cases is higher than in many larger hospitals. FRED J. COLEMAN, Dublin, is chairman of the staff of the hospital; JAMES F. O'DANIEL, Dublin, is vice-chairman; and W. PATRICK ROCHE, JR., is secretary.

RICHARD S. OWINGS, Augusta, has returned to Augusta to resume his practice of pediatrics. His new office is located in the Medical Arts Building, 1467 Harper Street. For the past two and a half years, Dr. Owings has been in the U. S. Army Medical Corps. A graduate of the University of South Carolina and the Medical College of South Carolina, Dr. Owings joined the staff of the Medical College of Georgia in 1951 as assistant professor of pediatrics and he maintained an office in the Medical School building.

At a recent symposium held at the Medical College of Georgia, V. P. SYDENSTRICKER, Augusta, led discussion on "Euthanasia"; FRANK JOHNSON, Macon, on "Telling the Truth to the Patient"; and L. L. BOWLES, Augusta, led the discussion on "The Obligation of Medical Education to Society." G. McLeod Bryan, Ph.D., professor of philosophy and Christian ethics, led the discussion on "Reverence for Life." L. D. Stoddard, Augusta, acted as moderator. The symposium was designed to present to medical students some of the ethical problems of the medical profession.

C. E. WILLS, Washington, has been elected by the mayor and city council to serve another three-year term as a member of the Board of Trustees of Washington General Hospital. M. C. ADAIR, Washington, who is a member of the City Council, said that the hospital is the only institution in that part of the state that is paying expenses, and that this is being done with lower rates than any other such hospital charges.

"Stop Rheumatic Fever"

A NEW HEALTH EDUCATION film—"Stop Rheumatic Fever"—has just been added to the AMA's Motion Picture Library. The film was developed to impress upon parents, teachers and the public the fact that rheumatic fever can be prevented by early diagnosis

and treatment of streptococcal infections. This 12-minute black and white sound film, employing symbolic animation to emphasize the point, is suitable for parent groups, service clubs, public health nurses, and high school students.

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The JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and Copyright, 1956, by the Medical Association of Georgia, 875 West Peachtree Street, N. E., Atlanta, Georgia. Published monthly under the direction of the Council of the Association. Subscription rates: \$5 per year; 1 per single copy. Entered as second-class mail at the post office at Atlanta, Georgia, under the Act of March 3, 1879. Accepted for mailing for the general rate of postage provided for in Section 1103, Act of October 6, 1917, authorized November 14, 1928.

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COVER

Gala Atlanta at night is depicted on the cover of this special issue. The bright lights of the big city add to the Official Call their call in neon for you to come to the 106th Annual Session. Cover by Ted F. Leigh, M.D.

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Some Clues in the Physical Examination of the Patient with Acyanotic Congenital Heart Disease

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WITH THE RAPID ADVANCE in our understanding of the pathological physiology of congenital heart disease, there has been great progress in our ability to make a definitive diagnosis without the aid of the more difficult laboratory procedures. It is the purpose of this communication to present some observations on why cases are missed and the limitations of the bedside examination at the present, and to suggest a systematic approach to the diagnosis of the common acyanotic lesions by physical examination.

The label "acyanotic congenital" not only limits the discussion to a few congenital lesions, but also defines a stage in their natural history, since any such patient with an intracardiac shunt may develop cyanosis with the onset of congestive failure or pulmonary hypertension, especially during exertion (cyanosis tardive). On the other hand, defects usually considered cyanotic (Tetralogy of Fallot, persistent truncus arteriosus, partial transposition), may be slow to develop this sign due to persistent patency of the ductus, good bronchial artery supply to the lungs, secondary anemias, negroid pigmentation, and probably poorly understood intracardiac streaming effects.^{1 2 3 4} Furthermore, certain combinations of defects may result in cyanosis of only one or two extremities (ductus with reversal of flow, transposition with ductus, absence of the aortic arch).^{5 6 7}

By far the most common cause of referral of an acyanotic child for further diagnosis is the discovery of a loud murmur. Much of this report, therefore, will be devoted to its differential diagnosis.

Obstructive or Shunt Lesions vs. Primary Myocardial Disease

It has been quite useful to divide cases when first seen into one or the other of these two categories. The division of given cases even into two general groups is sometimes difficult in children under the age of two. The most common of the "primary myocardial diseases" are endocardial fibroelastosis and myocarditis of unknown etiology. Aberrant left coronary artery, rhabdomyoma, medial sclerosis of the coronary artery, and Von Gierkes' Disease are rarer etiologies. Children or infants presenting generalized cardiac enlargement in the absence of significant murmurs, but with congestive failure and a loud rapid diastolic gallop usually have one of the above etiologies. This group has received much attention lately and is arbitrarily excluded from this discussion although they represent approximately 10 per cent of the non-rheumatic pediatric cardiacs seen by the authors in the last two years.⁸ Starting from the most peripheral part of the circulation where these defects occur, the common obstructive and shunt lesions are patent ductus arteriosus, coarctation of the aorta, aortic and subaortic stenosis, ventricular septal defect, pulmonary or subpulmonic stenosis, and auricular septal defect.

Diagnostic Approach

There are four important questions to be answered in the clinical investigation of the latter group. To the extent that this can be done by physical examination and history, the diagnosis can be made at the bedside; as will be pointed out, this is true in the great majority. It has been our practice to subject the patient to advanced diagnostic procedures only where the following bedside investigations were con-

Presented at the 105th Annual Session of the Medical Association of Georgia, Augusta, May 1-4, 1955.

DIAGNOSTIC APPROACH TO PHYSICAL EXAMINATION	
1. Which Ventricle is Enlarged?	<ul style="list-style-type: none"> a. Chest Wall Pulsation b. Prominent Left Chest
2. Status of Pulmonary Flow and Pressure?	<ul style="list-style-type: none"> a. Giant Jugular "A" Wave b. Pulsating Pulmonary Artery c. Pulmonic Second Sound d. Apical Diastolic Rumble
3. Status of Aortic Flow and Pressure?	<ul style="list-style-type: none"> a. Pulse Pressure b. Differential Blood Pressure c. Aortic Second Sound
4. Origin of Systolic Murmur?	<ul style="list-style-type: none"> a. Thrill and Intensity b. Location c. Character

Table 1

troversial. These questions are summarized in Table I.

1) *Which ventricle is enlarged?* The answer to this question is half the battle and is usually easy to determine by chest wall inspection and palpation. The right ventricle tends to enlarge anteriorly and with long-standing hypertrophy; the left chest is more prominent than the right. This sign can sometimes be found only by careful inspection, but it is practically pathognomonic of right ventricular enlargement. A second sign is due to vigorous pulsation of the enlarged right ventricle touching the anterior chest wall; this results in a systolic lift of the sternum in the more severe cases, and in milder degrees of enlargement, a parasternal systolic pulsation or anterior displacement of the rib-cage along the left sternal border. This is a clue rarely neglected by cardiologists, but not so well known among others. The only "false positive" occurs with an extremely large, dynamic left ventricle which may move the entire chest wall with each systole, but this is rarely confusing.

The normal left ventricle barely "taps" the chest wall during systole; when the left ventricle is hypertrophied, this faint apical motion is translated into a vigorous localized thrust, usually easily differentiated from the normal "tap". If there is only concentric hypertrophy and dilatation, it will be displaced downward and to the left. In cases of isolated right ventricular enlargement, the apex of the left ventricle is rotated posteriorly away from the chest wall, often with complete disappearance of the apex impulse. If both right and left ventricular enlargement are present, however, this usually does not happen; and both the localized apical systolic thrust and the parasternal or sternal pulsations are present.

Table 2 classifies the obstruction-shunt type of acyanotic lesions according to which ventricle is enlarged and emphasizes the importance of this part of the examination. It will be noted that ventricular septal defects may present only the findings of an enlarged left ventricle or may show combined hypertrophy. The true "Maladie de Roger" characterized by a loud systolic murmur with little or no cardiac enlargement has been infrequently found in our experience. Cases of auricular septal defect combined with rheumatic mitral valvulitis may have combined hypertrophy if mitral insufficiency is present, but if only stenosis exists (Lutembacher's Disease), the left ventricle is protected and isolated right ventricular enlargement occurs.

2) *What is the status of the pulmonary blood flow and pressure?* This is information more accurately obtained by fluoroscopy and catheterization, but it is surprising how often it can be qualitatively assessed by an informed physical examination.

The first information in this regard should be sought in the carefully crosslighted jugular vein; the three venous pulsations can usually be readily demonstrated except in infants or the very obese. Approximately half of our cases of pulmonary stenosis have exhibited a greatly accentuated A wave (Figure 1). This is a sign of tight pulmonary stenosis. The only

RIGHT	LEFT	COMBINED
Parasternal Lift Prominent Left Chest	Localized Apical Lift	(Both)
<i>Pulmonary Stenosis</i> <i>Auricular Septal Defect</i> <i>Lutembacher</i> <i>Primary Pulm. Hypertension</i> <i>Eisenmenger</i> <i>Anomalous Pulmonary Veins</i>	<i>Ventricular Septal Defect</i> <i>Patent Ductus</i> <i>Coarctation</i> <i>Aortic Stenosis</i> <i>Anomalous Coronary Artery</i>	<i>Ventricular Septal Defect</i> <i>Lutembacher</i> <i>Ostium Primum Defect</i>

Table 2
Classification of Acyanotic Lesions by Ventricular Enlargement

GIANT A WAVE RECORDED FROM SUPERIOR VENA CAVA
ISOLATED PULMONIC STENOSIS

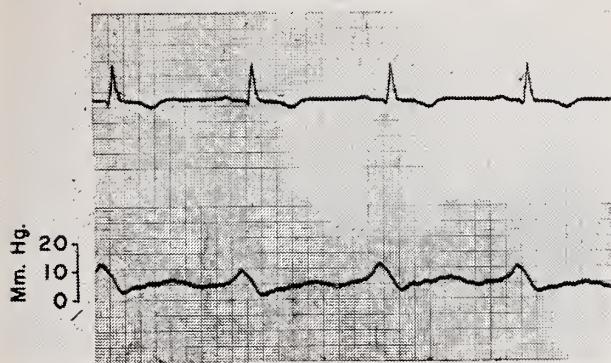


Figure 1

Simultaneous recording of EKG lead II (top) and a venous pulse through a nylon catheter. Note that the dominant wave in the venous pulse begins shortly after the P wave of the electrocardiogram and well before the QRS has begun indicating its auricular origin. Scale indicates a height of approximately 13 millimeters of mercury. This pulsation was easily visible with the patient sitting upright and its presystolic timing confirmed by simultaneous palpation of the carotid artery and auscultation.

other condition which gives a constant truly "giant" A wave is tricuspid stenosis.⁹ In both conditions, the accentuation of the A wave is due to contraction of the auricle against a high resistance with reflection of the auricular wave up the valveless internal jugular vein. It is much less common when septal defects are also present because the pressure generated by auricular systole is "decompressed" through the defect. This also is a sign which must be carefully sought, success in recognizing it requires practice, but the effort is rewarding.

An enlarged vigorously pulsating pulmonary artery may present a systolic pulsation in the second left intercostal space with palpable first and second heart sounds. In mild degree, this may be noted in any thin child, but must be interpreted as at least normal pulmonary flow and, depending on the vigor of the pulsations, may represent increased flow due to a septal defect or patent ductus. In our experience, it has been most common with auricular septal defect probably because this lesion classically has the larger and more pulsatile pulmonary artery.

The character of the pulmonary second sound deserves great attention. A sharply accentuated P_2 is good evidence of pulmonary hypertension. A very soft or inaudible pulmonary second sound is excellent evidence of pulmonary stenosis since the pressure distal to the stenosis is low, and gentle valve closure results in a soft sound. The sign is not so reliable in cyanotic cases (e.g., Tetralogy of Fallot) since when the aorta is partially transposed and close to the chest wall the aortic valve closure may be loudly evident in the "pulmonary area." Conversely, a loud split second sound is reason to believe that no pulmonary stenosis is present. Rare exceptions have been reported. Some examples or variations in the second sound are shown in Figure 2.

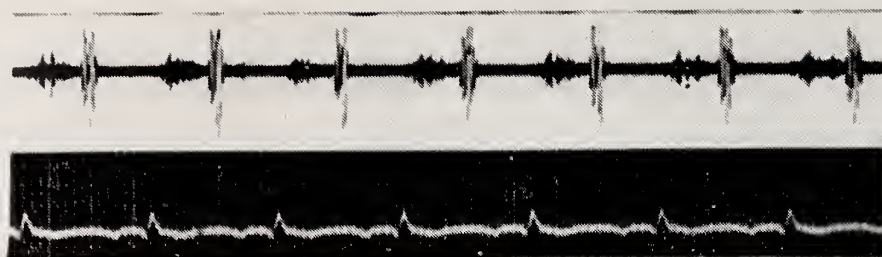
In cases with high pulmonary flow, an apical diastolic rumble is quite common. It was present in 11 of 12 recently studied ventricular septal defects at our clinic, although the usual figures given for the murmur of so-called "relative mitral stenosis" is in the region of 40 per cent.⁹ Its origin is presumably due to the passing of a large volume of blood through a normal mitral valve rather than a small or normal quantity's passing through a narrowed mitral orifice as is the case in organic mitral stenosis. This explanation does not explain its frequency in uncomplicated atrial defects since in this example mitral valve flow is not increased. When accompanied by a prominent third heart sound at the apex, usually attributed to rapid filling of the left ventricle, under the circumstances it is almost pathognomonic of a high pulmonary blood flow. When found, it narrows the diagnostic field to the septal defects, the patent ductus, and their less common physiological counterparts (anomalous pulmonary venous drainage, aorto-pulmonary septal defect).

3) *Status of aortic flow and pressure?* The narrow pulse pressure of aortic or subaortic stenosis does not seem to be found as often as in acquired aortic valvular disease. The impression of the narrow pulse of an obstruction to aortic outflow or the wide pulse pressure of aortic insufficiency or patent ductus must always be checked by sphygmomanometry. Accurate blood pressures are difficult to obtain in non-cooperative children, but since they may lead to a surgically correctable lesion, it is imperative that they be determined. The pediatric cuff must be used, and in infants this cuff can be folded to half its size. With a small pulse pressure and rapid rate, if auscultatory and palpatory methods are unconvincing, the "flush method" may give relative systolic pressures.¹⁰ It is impossible to examine adequately many infants without sedation. It has been our practice to sedate such children for a two to three hour period during which careful auscultation, observation of venous waves, chest wall pulsations, sphygmomanometry, and fluoroscopy are carried out. An inadequate examination of an infant due to his screaming and squirming, is often the cause of diagnostic failure.

A few words may be interjected at this point concerning coarctation. It is now trite to advocate routine palpation of femorals although, since only 10 per cent of our referred cases have been under 16, it seems fair to conclude that this is not often done in children. This has also been the experience elsewhere and is important since the optimal age for operation is about 12.¹¹ It is also not generally realized that a high percentage of coarctations have accompanying congenital defects. Their physical signs

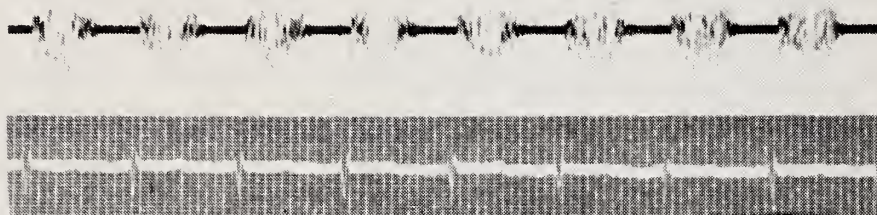
PARASTERNAL SYSTOLIC MURMURS OF CONGENITAL ORIGIN

AURICULAR SEPTAL DEFECT



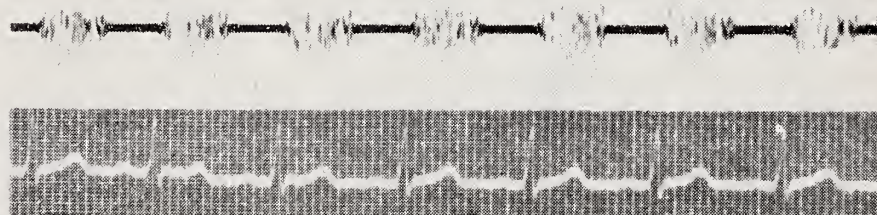
J B 9yrs. M. 9-28-54 Grade III

PULMONARY STENOSIS



M. T. 1yr 6mo. M. 5-4-54 Grade IX

VENTRICULAR SEPTAL DEFECT



C. O'H. 15yrs. M. 12-22-54 Grade V

Figure 2

Simultaneous phonocardiograms and EKG's of the three types of systolic murmur seen in congenital heart disease. For reference the first heart sound begins just after the QRS and the second sound at the end of the T wave. The illustrated characteristics can be identified with the stethoscope. Top record, recorded from the pulmonary area, shows a not very prominent decrescendo systolic murmur ending in a loud split second sound. The second murmur,

also recorded from the pulmonary area, illustrates the "diamond-shape" associated with stenotic lesions. Its peak is in mid-systole and the second sound is almost indistinguishable. The murmur of aortic stenosis is identical but differs in location. The last murmur (bottom) was recorded along the lower sternal border and ends in a very loud second sound.

may satisfy the examining physician, and once a diagnosis is made no further investigation is done. Congenital or acquired mitral stenosis, bicuspid aortic valve with aortic insufficiency, patent ductus arteriosus, septal defects, or aortic arch anomalies are found in approximately 30 per cent.⁹ An occasional case is also seen with palpable albeit weak femoral pulsations. The delayed pulse in the femoral relative to the radial artery is difficult to detect without graphic methods, and it has therefore been our practice to take blood pressures in three extremities in any child or young adult with heart disease.

Some interesting patterns of blood pressure are noted due to the differences in location of the coarcted segment. If the coarctation is distal to the origin of the left subclavian, blood pressure will be high in both upper extremities and low in the others. If, however, the right subclavian has an anomalous origin from the descending aorta, the blood pressure

will be high only in the left arm and low in the other three extremities.¹² If the coarctation is between the innominate and the left subclavian, hypertension will exist only in the right arm.¹³

The intensity of the aortic sound is also of interest; in congenital aortic valvular stenosis, the sound is sharply diminished, although the pulmonary sound may be quite loud. If the aortic obstruction is subvalvular, the aortic second sound is said to be well preserved.

4) *What is the origin of the systolic murmur?* Figure 3 illustrates the usual location of the point of maximal intensity of these murmurs. Careful auscultation, particularly of loud murmurs, is necessary to secure the localization. From Figure 3, it can be seen that only one is maximal to the right of the sternum. This murmur of aortic or subaortic stenosis is usually well transmitted to the secondary aortic area and neck vessels. Only one significant systolic murmur is seen

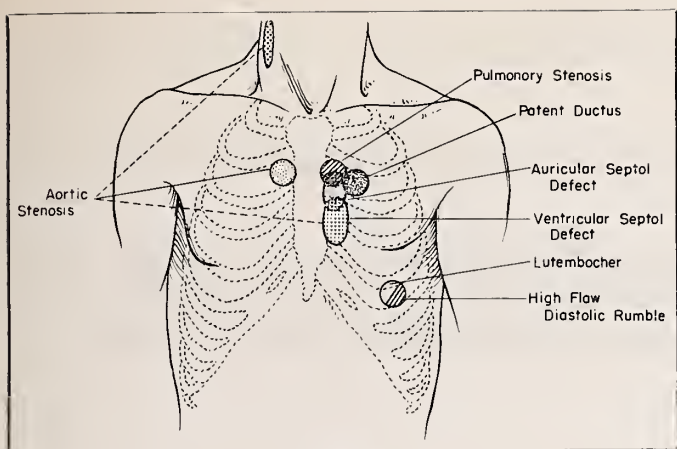


Figure 3

Characteristic locations of the murmurs heard in acyanotic congenital heart disease. The overlapping murmurs along the left sternal border create the most confusion, but can usually be differentiated (see text).

at the apex in acyanotic heart disease, and it is usually due to the mitral insufficiency of a complicating rheumatic mitral valvulitis. The murmurs of pulmonary stenosis and the septal defects are commonly confused, principally because, as illustrated, their locations overlap. Their intensity gradings also overlap, but usually they can be differentiated on other grounds. A thrill is infrequent with auricular septal defect and common with pulmonary stenosis. The pulmonary second sound in auricular septal defect is usually loud and widely split whereas in pulmonary stenosis, it is soft and practically always single. The murmurs of pulmonary stenosis are usually graded from 3-5 and those of auricular septal defects from 1-4. (Levine classification, grade 1-6).¹⁴ The murmur of ventricular septal defect is usually in the 3-4 left intercostal space, almost always associated with a thrill, and is of grade IV or greater intensity. It is unlikely that a murmur of this intensity and location represents anything except a ventricular septal defect, regardless of what other complicating lesions are present, although acquired or congenital tricuspid insufficiency must be considered. It is said that if the ventricular septal defect is very large, there may be a relatively small pressure differential between the two chambers with a low velocity of flow between the left and right ventricle. This results in a much softer murmur. A very small defect may have the same result due to the small volume of shunt. We have observed two catheter-proven cases of ventricular septal defect with severe pulmonary and right ventricular hypertension with soft systolic murmur. One of these was known to have had a very loud murmur two and half years previously. It is possible that with the onset of pulmonary hypertension and a decrease in pressure gradient across the defect, the murmur decreased in intensity. In our experience, however, these cases are unusual.

The "diamond-shaped" murmur of aortic or pulmonary stenosis has a phonocardiographic configuration with peak intensity in mid-systole. These features can usually be recognized stethoscopically because of diminuendo intensity in late systole ending with a very soft or indistinguishable second sound. These murmurs are illustrated in Figure 2.

Diastolic Murmurs of Congenital Origin

1) *Patent Ductus*: In Figure 3, it can be seen that the maximal intensity of a ductus murmur is usually a little way out from the left sternal border in the second intercostal space. Its auscultatory characteristics are so well known that little comment is required. The systolic component is usually crescendo, and the second sound is fairly loud although the appearance of a loud diastolic component immediately after the second sound often makes the latter difficult to distinguish and gives the murmur its characteristic "continuous" quality. This crescendo character of the systolic component is said to be preserved even when pulmonary hypertension diminishes the diastolic shunt and consequently causes disappearance of the diastolic element.¹⁵

It must be pointed out that all continuous murmurs are not due to a patent ductus arteriosus, although in the above described location they almost always are. In coarctation, an occasional continuous murmur may be heard over the enlarged intercostal arteries; in some patients with defective pulmonary arterial supply and enlarged bronchial arteries, the murmur presumably arises from this source. The most common continuous murmur, however, is that of venous hum. Depending on its location it may simulate a patent ductus, or the diastolic component may suggest aortic insufficiency. Manual occlusion of jugular venous flow will dramatically abolish this murmur. The systolic-diastolic murmurs of acquired aortic stenosis and insufficiency may on occasion resemble that of the ductus, but a careful localization of the PMI and attention to the second heart sound should eliminate confusion.

2) *Apical Diastolic Rumble*: This murmur mentioned previously as a sign of high pulmonary blood flow is best heard at the apex. Its presence has been the cause for several cases seen in the last year to be labelled "mitral stenosis." It cannot be distinguished with certainty from the murmur of mitral stenosis, although there are a number of helpful hints on auscultation. High flow rumble is usually mid-diastolic in time and frequently follows an apical third heart sound, not heard in tight mitral stenosis. The presystolic accentuation and snapping apical M_1 of mitral stenosis are usually not present, although we have heard some murmurs which did seem to have these characteristics confirmed by the phonocardiogram. The opening snap of the mitral valve maximal

DIASTOLIC MURMURS OF CONGENITAL ORIGIN

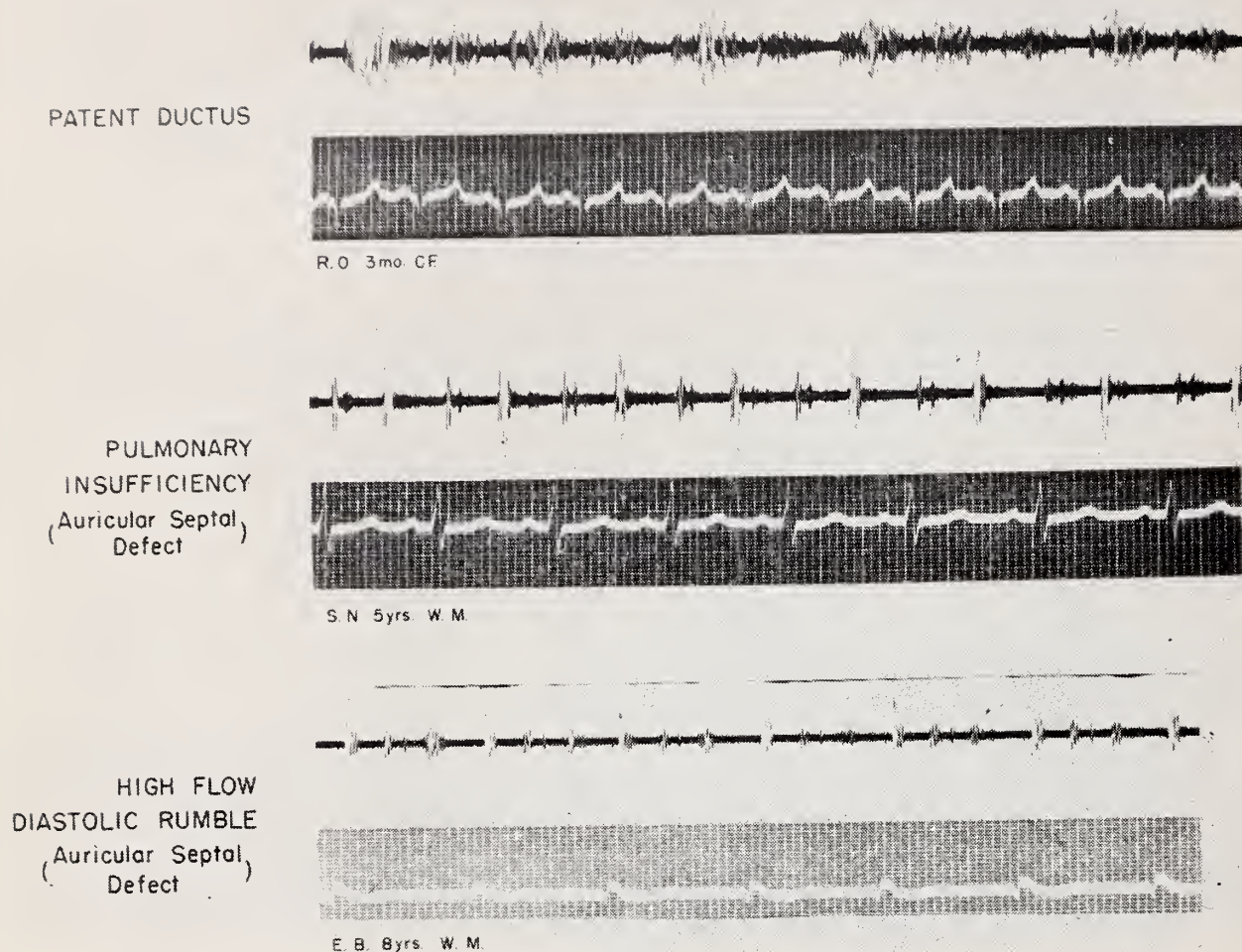


Figure 4

Simultaneous recordings of phonocardiograms and EKG's of the three common diastolic murmurs in congenital heart disease. Top—continuous murmur of patent ductus. Second sound can be identified in most complexes by the peak occurring simultaneously with the end of the T wave. The base line of the phonocardiogram is continually in motion except for a few milliseconds preceding the QRS in a few complexes. Middle—after the loud second sound decrescendo, high frequency vibrations are constantly seen. Mur-

mur recorded down left sternal border, loudest at pulmonary area. A systolic murmur of moderate intensity is also present. Bottom—recording from apex. The second sound is widely split and the second element faint in this area. In early to mid-diastole, there are rather intense low to mid-range frequency vibrations. Stethoscopically intensity grade of this mid-diastolic murmur was III. There is no presystolic accentuation, but first heart sound is fairly loud.

along the lower left sternal border is present only in mitral stenosis. The associated parasternal murmur of a septal defect or ductus usually indicates the congenital origin of the disease since loud parasternal systolic murmurs are rare in rheumatic heart disease. The other findings of high pulmonary blood flow are confirmatory when present. History of rheumatic fever may also be of assistance.

3) *Pulmonary Insufficiency*: Organic defects involving the pulmonary valve usually result in stenosis rather than insufficiency. Dilation of the pulmonary artery secondary to a high pulmonary blood flow may, however, result in functional insufficiency of the valves. The incidence in auricular septal defect is said to be approximately 20 per cent;⁹ it is unusual in other lesions with a high pulmonary flow. Such a murmur is illustrated in Figure 4. Congenital aortic

insufficiency is extremely rare, but we have observed one three-year-old with a loud murmur of aortic insufficiency present since the neonatal period, without evidence of bacterial endocarditis or associated lesions. It is likely that a congenitally bicuspid or fenestrated aortic valve is present in this case. The murmurs of aortic and pulmonary insufficiency are difficult to differentiate on auscultatory grounds alone since their localizations are so similar. It is not surprising, therefore, that an occasional auricular septal defect with both apical and parasternal diastolic murmurs has been referred as a case of rheumatic heart disease. This was true in the case whose phonocardiogram is shown in Figure 4. The physical signs of high pulmonary blood flow and of isolated right ventricular enlargement were present and there were no peripheral signs of aortic insufficiency.

AMA's June Meeting Will Be in Chicago

PLANS ARE RAPIDLY TAKING SHAPE for the AMA's 105th Meeting June 11-15 in Chicago. AMA has lined up nearly five full days of lectures, scientific and technical exhibits, color television and motion picture presentations to give physicians a good "short course" in post-graduate medical education. Between 12,000 and 15,000 physicians are expected to attend the convention which will center its activities at Navy Pier, Northwestern University, and near northside hotels. Headquarters for the House of Delegates will be at the Palmer House.

Some 350 Technical Exhibits and more than 300 Scientific Exhibits will be on display all week for the benefit of physicians and guests. The exhibit hall will be open "for doctors only" probably on Wednesday and Thursday mornings.

A few outstanding scientific features already scheduled include: fracture and fresh pathology exhibits; physical examinations for physicians; exhibit-symposiums on traffic accidents and arthritis and rheumatism; special exhibits on cardiovascular diseases and pulmonary function tests.

. . . Acyanotic Congenital Heart Disease (cont'd)

Summary and Conclusions

Three years' experience in a diagnostic referral clinic has been analyzed with regard to cases of the common acyanotic congenital heart diseases. The following conclusions seem valid.

1) Physical examination methods currently available are usually adequate for qualitatively determining the answers to the four questions necessary for diagnosis in each case. These are: (1) Which ventricle is enlarged? (2) What is the status of the pulmonary blood flow and pressure? (3) of the aortic flow and pressure? (4) What is the origin of the systolic murmur?

2) The commonest source of confusion is in the differential diagnosis of the left parasternal systolic murmurs of pulmonary stenosis and the septal defects. Careful search for the PMI, accentuation or diminution of the pulmonary second sound, for evidence of ventricular dominance, and high or low pulmonary blood flow usually allows differentiation of these three lesions at the bedside.

3) The diastolic murmurs present are usually due to the patent ductus, to pulmonary insufficiency, or high pulmonary blood flow. These often result in the erroneous diagnosis of combined or isolated rheumatic valvulitis.

4) Three errors apparently account for most mistakes in the diagnosis of coarctation. First, the presence of the signs of associated anomalies overshadow the surgically correctible lesion of the aorta. A second cause is the presence of palpable femoral arteries. This error can be avoided by routinely recording blood pressures in three extremities. Sedation, proper cuff sizes, and occasional use of the flush method may be necessary. Lastly, since over 90 per cent of

referred coarctations have been over 16 years of age, it is likely that the diagnosis is being missed in the pediatric age group.

Medical College of Georgia

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Dwarfs

A Discussion of Four Causative Conditions

J. HIRAM KITE, M.D., Atlanta, Ga.

THE TERM "DWARFISM" in a broad sense includes all conditions characterized by stunted growth. The term therefore requires some qualification. The term "nanism" is used to imply conditions in which there is impairment of growth only. The term "infantilism" applies to individuals in whom there is impairment of growth, sex, and intellect. Dwarfing may be disproportionate or proportionate. There are more than a dozen conditions which will cause dwarfing. Only four will be mentioned here.

In the animal world we also see dwarfing. The dachshund has a normal length spine but very short legs, like the achondroplastic. The bull dog has a short deformed spine and head but normal legs, similar to the chondro-osteo-dystrophy cases of Morquio.

Achondroplasia

Achondroplasia is the commonest type of dwarfism and perhaps the most ancient. Parrot in 1878 suggested the title, achondroplasia. It is only rarely hereditary. It has been traced through several generations in the male line. Difficulties in labor in the female achondroplastic interfere with inheritance. The characteristics are present at birth. In cretinism and Morquio's disease the typical features develop later. Achondroplasia is the result of an inherent developmental fault in the ovum. The cause is unknown. Twenty cases have been studied at the Scottish Rite Hospital for Crippled Children, Decatur, Ga., and in my office. (Figure 1.)

The reduction in height is due chiefly to the shortness of the legs. Achondroplastics may vary in height from two feet six inches to four feet. The long bones are short. The fingers may not reach below the greater trochanters. The proximal segments of the limbs are more affected than the distal segments. The head is suggestive of hydrocephalus. The hands are short and broad, and sometimes the middle finger is the same length as the second and fourth. In some cases there is the trident hand of Marie, which results from the thumb's deviating laterally and the fifth finger medially from the second, third, and fourth fingers

Figure 1

One year old achondroplastic. The head is enlarged, measuring 10 cm. more than the circumference of the chest. He had been diagnosed hydrocephalum. The arms are short. The fingers do not come quite to the crest of the ilium. The hands are small. The third finger is short. There are abnormal creases in the arms, one above the wrist and two in each upper arm. The folds are deeper than normal in the thighs. The legs are short, and the feet small. The trunk is of normal length. The mid-point of his height is between the umbilicus and the xyphoid.



which remain parallel. The legs are often bowed.

The general appearance of the limbs is one of sturdiness with some enlargement of the ends of the bones. The muscular development is above average so that they may perform feats of strength. Sexual development is normal. Intelligence is normal. The bones are short and rather dense in the roentgenograms. The femurs and humeruses may be less than two-thirds of the normal length. The medullary canal is reduced in size. There is splaying of the ends of the long bones, and the epiphysis may be small and appear to be drawn into a notch in the metaphysis. The growth of the cartilage cells is disorderly. Periosteal ossification is normal.

Morquio-Brailsford Type of Dwarfism

In 1929 Morquio described "A Form of Familiar Osseous Dystrophy" seen in four members of a family of five. Brailsford suggested the name, "Chondro-osteo-dystrophy," for a similar patient. The developmental error is seldom apparent before the child begins to walk. It is more noticeable after four. Both sexes are affected. Hereditary influences are rare, but familial influences are common. The cause is unknown. (Figures 2 and 3.)

At about four years of age it is noticed that the child is failing to gain in height, and that a curvature of the spine is developing. The back is rounded and

Presented at the 105th Annual Session of the Medical Association of Georgia, Augusta, May 1-4, 1955.



Figure 2A

Morquio's chondro-osteo-dystrophy in a sister 11 years old and a brother eight years old. There has been no one on either side of the family for several generations who has had a similar condition. The girl was four and the boy two before anything abnormal was noticed. These children are weak and stand in a crouching position. They are knock-kneed. The joints are enlarged. The fingers come down to the level of the knees.



Figure 2B

Lateral view of the brother. There is a kyphosis in the dorsolumbar region suggestive of tuberculosis. The neck is short. The limbs are normal in length. The shortening is in the spine. The roentgenograms show a marked flattening of the vertebral bodies, with a central tongue-like prolongation anteriorly. They showed no epiphysis for the head of the femur in their last X-rays at 19 years. The bases of the metacarpals are pointed. They were unable to walk without crutches by the age of 12. Each measured only 39 inches tall when growth was completed.



Figure 3

Fourteen-year-old dwarf standing beside her three-year-old sister. She is typical of Morquio's disease. She was knock-kneed, but the legs have been made straight by tibia osteotomies. These dwarfs never become more than a meter tall. The facial expression is that of an older person. The neck is short and so is the trunk. The last roentgenograms of the wrists at 15 years show an absence of the carpal naviculars and lunates.

the neck seems short. The child stands in a crouching position with the hips and knees flexed. The knees show knock-knee deformity, the feet are flat, and there is a waddling gait. Later the child can walk only with support. There is a kyphosis at the dorso-lumbar region suggestive of tuberculosis. The shortness in stature is due to the flattening of the bodies of the vertebrae. The limbs are normal in length. The fingers reach to the knees. There is a laxity of the ligaments with hypermobility. This is seen best in the wrists. There may be enlargement of the finger joints suggestive of arthritis.

The roentgenograms show a marked flattening of the vertebral bodies, which is more marked in the dorsal region. The lateral view shows the bodies to have a slight wedge-shaped appearance, with a central prolongation or tongue anteriorly. Usually there is one vertebral body near the dorsolumbar junction which is smaller and is displaced backward. There is irregular development of the epiphysis. The head of the femur has failed to appear in some cases. The bases of some of the metacarpals, especially the third and fourth, tend to be pointed. Ossification of the carpus is usually delayed, and when ossified the bones are irregular.

The pathology is unknown. The condition progresses until the patient is unable to walk without assistance.

Gargoylism

Gargoylism—Hurler's Syndrome—Dysostosis multiplex

This type of chondro-osteo-dystrophy is characterized not only by dwarfism, but also by a heavy, ugly facies, corneal opacity, mental deficiency, kyphosis, distension of the abdomen, and enlargement of the liver and spleen. (Figure 4.) There is little evidence that heredity plays any part in this condition. Both sexes are affected. This condition may be classified with the lipoidoses. At birth the child may be above the average, but after the first year there is increasing evidence of dwarfism. The head is large, the eyes are wide apart, the bridge of the nose depressed, and the general facies is ugly. The open mouth and enlarged tongue may suggest cretinism. Cloudiness of the cornea is a striking feature. There is usually some mental deficiency. The liver and spleen are enlarged, and the abdomen distended. Frequently there is an umbilical or inguinal hernia.

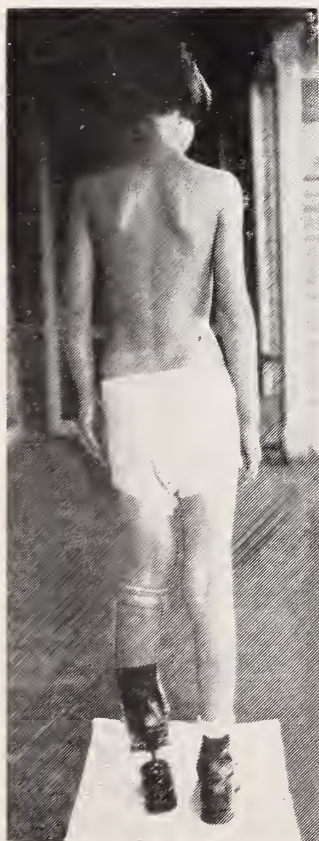
The roentgenogram shows an enlargement of the sella turica and sometimes signs of hydrocephalus. The vertebrae show the superior and inferior surfaces

Figure 4

Seven-year-old boy with typical Gargoylism, or Hurler's type of chondro-osteo-dystrophy. He is not only a dwarf, but is very weak and cannot stand alone. He has heavy, ugly facies, corneal opacity, a kyphosis, and distension of the abdomen, which is larger than accounted for by the enlargement of the liver and spleen. He also has an umbilical hernia. Mentality is very low. He cannot talk or feed himself. There is limitation of motion in shoulders and elbows and in rotation of forearms. The fingers are short and the joints enlarged. There are only two carpal bones ossified at seven. The neck is short and the roentgenogram shows a platybasia. The intraocular tension was 75 instead of 30. The cornea is too cloudy for the disc to be seen.



of the bodies to be convex, giving biconcave discs. There may be a kyphosis about the dorsolumbar region, and one body may be small and displaced backward as in the Morquio-Brailsford type, but the bodies do not have the same type of tongue-like processes anteriorly as seen in the Morquio-Brailsford type. There may be irregular ossification of all of the epiphyses, with delay in ossification and delay in fusion with the shaft. Usually there is a gradual deterioration and the child dies before growth is complete.



Ollier's Disease

Dyschondroplasia
Multiple enchondromata

Ollier in 1900 described a rare condition characterized by rounded masses or columns of unossified cartilage in the metaphyses and diaphyses of certain bones. At the epiphyseal line nests of cartilage become mis-

Figure 5

Nine-year-old girl with Ollier's unilateral multiple enchondromata. X-ray shows involvement of the left humerus, radius, ulna, hand, femur, tibia, fibula, and bones of the foot, with no involvement on the right except in two ribs. The left leg is over six inches shorter at nine years, and is bowed and enlarged above the ankle. A brace is needed for walking.

placed instead of being calcified. Here the masses of cartilage are found inside the metaphyses, they are endosteal and are not projections on the surface as are exostoses. Heredity plays no part. Both sexes are affected. The cause is unknown. (Figure 5.)

It is usually a unilateral condition, but occasionally a lesion may be found on the opposite side of the body. It involves chiefly the long bones, and is more in the end of the bone which is growing the most rapidly. It is frequently seen about the wrists and knees. The ulna, as in many forms of dwarfism, is shorter than the radius, and the radius is curved. The metacarpals and metatarsals and the phalanges are favorite sites for numerous enchondromata and cause many disabling deformities. (Figure 6.) Here the masses of cartilage may proliferate. The enchondromata may grow to considerable size and break through the cortex and fungate, causing considerable crippling.

490 Peachtree St., N.E.

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Figure 6

Hands of the patient in Figure 5, at the age of 25. The enchondromata of the metacarpals and phalanges have grown until the hand cannot be used. A little later the enchondromata fungated and drained, and the fingers had to be amputated.

Blood Transfusion in the Treatment of Bleeding Following Adenotonsillectomy

JAMES T. KING, M.D., Atlanta, Ga.

THE OBJECT OF THIS REPORT is to present some of the advantages and practical aspects of the use of blood transfusion in the treatment of hemorrhage following adenotonsillectomy in children. In a series of nine such consecutive cases (1951-1955), this treatment successfully reduced the need for the measures ordinarily used in the management of this complication.¹⁻⁵ The readministration of an anesthetic to a partially exsanguinated child with an obstructed airway, in order to check postoperative bleeding, can be one of the most dangerous procedures in all surgery. Even minor procedures under local anesthesia are unpleasant to say the least.

A surprising benefit of this therapy was its apparent hemostatic effect. In eight of the nine cases in this series the bleeding stopped before the transfusion was completed and without recourse to any other manipulation or instrumentation. Even clots were left undisturbed. In the ninth case a bleeding vessel was crushed under local anesthesia prior to administration of the transfusion.

The chief advantage of this treatment is, of course, the replacement of blood loss. However, it is often difficult to calculate accurately the amount lost. In a small child, especially, the relative blood loss is easily misjudged and on more than one occasion, prior to this series, when it seemed that a child had lost only a small amount of blood, a surprising degree of secondary anemia was later found to be present. In this series, after the bleeding had stopped, return of the pulse rate to normal proved a reliable clinical indication that the blood loss had been replaced, as subsequent blood counts showed no anemia.

Consideration was given to the conservation of veins and elimination of as many venipunctures as possible in the use of this method of treatment. Multiple venipunctures not only deplete the limited number of readily accessible veins, but render the child less cooperative because of added pain and terror. The single venipuncture method was therefore used.

In this procedure, as soon as it is apparent that a child is bleeding postoperatively, a good arm vein is selected and an arm board is put securely in place. A new 19 or 20 gauge needle is left in the vein and a glucose infusion is started through it. Preparation is made to facilitate the vomiting of blood in order to prevent dislodging the needle in this event. When the blood for transfusion is ready, it is then given through the same needle.

The greatest amount of blood used in this series was 500 cc. and the average amount was 325 cc. No untoward reaction was noted.

Summary

1. Blood transfusion was the principle treatment used to control hemorrhage following adenotonsillectomy in a series of nine children.

2. This treatment apparently exerted a hemostatic effect in addition to replacing blood loss.

3. A practical routine for avoiding multiple venipunctures is presented.

384 Peachtree Street, N. E.

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Presented at the 105th Annual Session of the Medical Association of Georgia, May 1-4, 1955, Augusta, Ga.

All people attending the Annual Session are urged to visit the Emergency Hospital Exhibit at the First Baptist Church. (See page 128)

How to Treat a Guest Speaker

WHEN GUEST SPEAKERS are invited to a meeting, it is customary to designate a local member as his sponsor for the duration of his visit. This sponsor may know the speaker, or he may never have seen him before. In either event, certain responsibilities rest with the sponsor, and his failure to live up to these may detract from an otherwise successful visit. No two individuals can be treated in exactly the same manner, but the end result should be that the speaker and participating members feel that his visit was a success. Thus we are "bold" enough to lay down a few principles to be followed in sponsoring a guest.

1. Do not monopolize him. The majority of speakers have their expenses paid by the organization which is holding the meeting. It is for this purpose that registration fees and dues are paid. The speaker is thus the property of everyone in attendance and not solely for the edification of his sponsor.

2. Do not pull him away from the meeting. Recently, the sponsor of a guest speaker rather rudely broke up an enjoyable post-session discussion by stating, "That's enough, fellows, Dr. ——— has only a short time to get some sunshine." He then cleared the way for the guest to leave the hall. This sudden exodus deprived several members of the group of the chance of meeting the speaker.

3. Make him comfortable. Although the speaker is the property of all attending the meeting, it is necessary that he receive an adequate amount of rest. The host should be able to arrange the schedule so that a fair opportunity is given for personal contact with the speaker, and still permit him to have sufficient moments of solitude.

4. Give priority to his attendance at official functions. In spite of the fact that some luncheons and banquets are not exactly "a gourmet's delight," it seems grossly unfair that any of the guests should fail to appear. Many times this is the only opportunity afforded members to meet the speakers. It is the host's duty to encourage the guest to attend these functions, rather than to tempt him away to some favorite eating spot. In recent years, vacancies at the speakers' table have been most embarrassing.

5. Make every effort to see that he meets as many of the men in his line of work as is possible. If he has any particular friends in the city, make it possible for him to spend a little of his time with them. How-

ever, care must be exercised to see that these friends do not interfere with his responsibilities to the individuals who are "paying the bill."

6. Don't leave him stranded. At banquets, at cocktail hours, and in other crowded circumstances, don't let the guest get "stuck like a teenager at his first dance." Above all, let no question arise about transportation. Several times guests have arrived late because of failure on the part of the host to arrange for adequate and prompt transportation. Furthermore, no host should fail to provide transportation for his guest to the airport or his other means of departure from the city. On several occasions, after entertaining the guest for several days, hosts have been observed to foist him off on someone else to provide his transportation to points of communication with other cities. This practice is not only unfair to the speaker, but is also somewhat unfair to the individual requested to provide last-minute transportation.

7. Acquaint yourself with the needs of the guest speaker's wife. It is incumbent upon any host to find out in advance whether or not the speaker's wife is to attend the meeting with him. Should this be the case, every effort should be made to see that her time is adequately filled, particularly when there are no ladies' auxiliary activities in which she can take part. In these circumstances, the host will usually find that his wife is the proper individual to take care of the wife's entertainment.

8. The expenses for the guest speaker are taken care of by the proper individuals without his finding it necessary to inquire regarding financial matters. If you are in doubt, contact the secretary of the organization sponsoring his visit and ascertain the exact financial arrangements which have been made with him.

By adhering to the above principles, our treatment of guest speakers should improve. Since the South is well known for its hospitality, we should bend every effort in the direction of continuing to warrant this distinction.

Chlorpromazine Jaundice — An Iatrogenic Disorder

SINCE ITS INTRODUCTION in the United States in May 1954, under the trade name Thorazine, chlorpromazine has been widely prescribed in the treatment of nausea and vomiting, mental disturbances,

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alcoholism, severe pain, and many other conditions. It is a very potent, versatile, and valuable drug.

Although the manufacturers have cautioned physicians to be on the alert for the possible development of jaundice in a small percentage of patients receiving chlorpromazine, many doctors apparently have not yet become familiar with the clinical and laboratory characteristics of this serious complication. The exact incidence of the occurrence of jaundice in the patients receiving the drug over a period of weeks is not known, but it is probably around one per cent. Most of the cases reported seem to develop after about two weeks of therapy, using average doses.

In a typical case, the patient develops fever and grippe-like symptoms, dark urine, light stools, and jaundice. Pruritis is often a troublesome symptom. The physician's first clinical impression is usually that he is dealing with a case of infectious hepatitis. However, the thymol turbidity and cephalin flocculation tests, i.e., tests of hepatic function, are consistently normal. Also, elevation of the serum alkaline

phosphatase and cholesterol values further suggest an obstructive type of jaundice.

Chlorpromazine jaundice, if the drug is discontinued immediately, usually persists about two weeks, but often it may last for months. Because of the laboratory findings, which point toward an obstructive type of jaundice, many of these patients have been subjected to exploratory laparotomy. Biopsy of the liver has revealed blockage of the smaller biliary radicles with inspissated bile, and varying degrees of periportal inflammation. In essence, the jaundice is of the intrahepatic, obstructive type.

Chlorpromazine jaundice must be considered in the differential diagnosis of all jaundiced patients. Where there is a history of chlorpromazine administration, exploratory laparotomy should be postponed unless there is clear evidence of extrahepatic obstruction. Furthermore, this drug should not be prescribed unless definitely indicated, and unless the benefits anticipated by its use clearly outweigh the risks involved.



Before

Crawford W. Long Memorial

AS YOU CAN SEE by the pictures, there has been quite a change in the proposed museum site in Jefferson, Georgia. This change was brought about through the generosity of Governor Eugene Talmadge, who during his late days in office, designated a sizeable sum of money to be spent for this purpose. As you can see, this purpose has been partially accomplished.

Members of the committee in Jefferson, Georgia, have seen to it that the money was well spent, and the building now is in a quite satisfactory condition. The only things lacking are the contents for the interior which will constitute a memorial hall downstairs and a museum telling the story of the development of anesthesia upstairs.

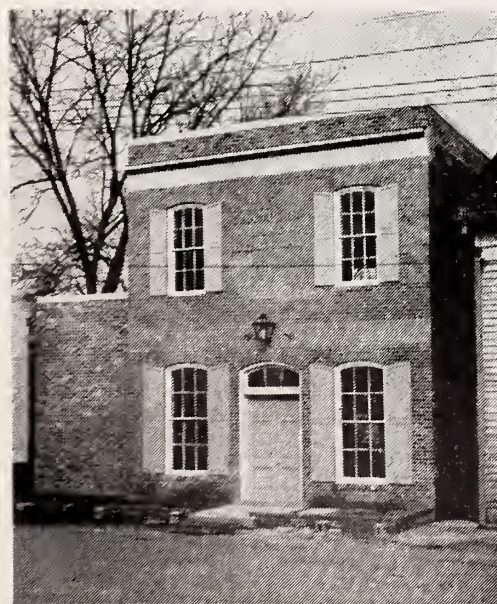
The Medical Association of Georgia is now maintaining this building, and so far this is adequately carried out by the appropriation to our committee.

It is anticipated that the building will be completed sometime this year as far as interior furnishings are concerned, again with the probability of help from the historical commission in this regard.

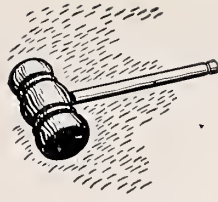
During the interim, it is anticipated that certain items of historical interest will be placed as "fill-in" material, until the final historical documents are obtained. Anyone who has such items related to the first administration of ether anesthesia, be they letters, documents, etc. should get in touch with the office of Mr. Frary Elrod in Jefferson, Georgia.

It is anticipated that by this time next year, we will be able to have not only a building, but an interior which will do justice to the magnitude of the event which it commemorates.

*Lester Rumble, Jr., M.D., Chairman
Crawford W. Long Memorial Committee*



After



president's page

I AM PRIVILEGED TO HAVE this occasion to extend a cordial invitation to every member of the Association to attend and participate in the 106th Annual Session of the Medical Association of Georgia to be held May 13-16, 1956, at the Atlanta Biltmore Hotel.

The program for this session has been extremely well arranged to meet the interests of physicians in all fields of medicine. 29 out-of-state guest speakers will present the latest scientific developments being used in their areas, and leaders of the profession in Georgia will report on their medical activities. The Association's House of Delegates will convene to consider and legislate Association policy for 1956-57. Our Scientific Work Committee deserves the praise and gratitude of all members for organizing such a well-rounded program.

The Fulton County Medical Society has planned many social events and the Local Arrangements Committee has strived to make this a memorable occasion. The Woman's Auxiliary to the Medical Association of Georgia has also arranged a splendid program for Auxiliary members, and your wives may look forward to an enlightening and enjoyable round of activities.

In the non-scientific area, the general practitioners are highlighting the session with a program on the topics: "The Physician and Theology" followed by an actual courtroom demonstration put on by members of the AMA Law Department, titled "The Physician as an Expert Medical Witness." Scientific exhibits are more numerous at this session than ever before and a word of appreciation is due the commercial exhibitors who support our meeting.

With the largest Association membership on record, our 106th Annual Session in Atlanta promises to be the best attended meeting yet held. As president of your state medical organization, I wish to urge every practitioner to attend and participate in this event of the year. My term of office comes to an end at this session, and I would appreciate the opportunity to thank each member personally for his enthusiastic support during the past year.

H. D. Allen, Jr.

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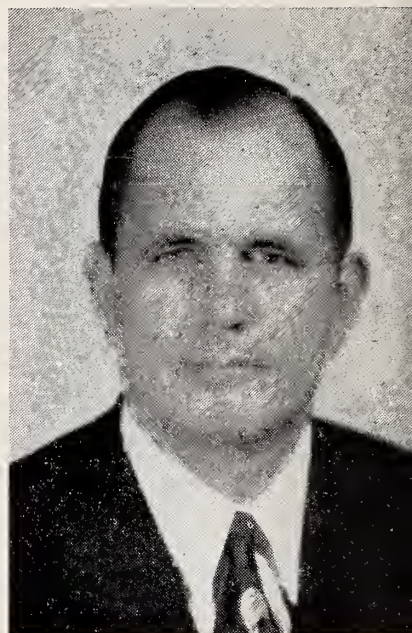
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James A. Redfearn	President, 1942-1943
W. A. Selman	President, 1943-1944
Cleveland Thompson	President, 1944-1946
Ralph H. Chaney	President, 1946-1947
Enoch Callaway	President, 1949-1950
A. M. Phillips	President, 1950-1951
W. F. Reavis	President, 1951-1952
C. F. Holton	President, 1952-1953
William Harbin	President, 1953-1954
Peter B. Wright	President, 1954-1955

Professional Conduct

A. M. Phillips, Macon, *Chairman*
W. F. Reavis, Waycross
William Harbin, Rome
C. F. Holton, Savannah
Peter B. Wright, Augusta

History and Vital Statistics

J. Calvin Weaver, Atlanta, *Chairman*
Peter L. Scardino, Savannah
Hoke Wammock, Augusta

Public Health

T. A. Sappington, Thomaston, *Chairman*
Duncan Shepard, Atlanta
L. Minor Blackford, Atlanta
Grady N. Coker, Canton
J. E. Scarborough, Atlanta
R. F. Spanjer, Cedartown
David R. Thomas, Jr., Augusta
Edgar M. Dunstan, Atlanta
J. C. Thoroughman, Atlanta
Peter Hydrick, College Park
T. F. Sellers, Atlanta, *Ex-Officio*
J. C. Hughston, Columbus
Rives Chalmers, Atlanta

Maternal and Infant Welfare

Peter Hydrick, College Park, Chairman

Thomas C. McPherson, Atlanta Eugene L. Griffin, Atlanta
C. M. Mulherin, Augusta F. H. Simonton, Chickamauga
Helen W. Bellhouse, Atlanta George H. Alexander, Forsyth
Hugh J. Bickerstaff, Columbus James W. Bennett, Augusta

Woman's Auxiliary

Shelley C. Davis, Atlanta, Chairman

W. G. Elliott, Cuthbert Robert C. Major, Augusta
W. Bruce Schaefer, Toccoa

Constitution and By-Laws

J. W. Chambers, LaGrange, Chairman

Thomas W. Goodwin, Augusta Eustace A. Allen, Atlanta
William Harbin, Rome David Henry Poer, Atlanta

Awards

Ted F. Leigh, Atlanta, Chairman

Hoke Wammock, Augusta Mark S. Dougherty, Atlanta
Charles H. Wasden, Macon

Industrial Health

Duncan Shepard, Atlanta, Chairman

John G. Sharpley, Savannah W. Bruce Schaefer, Toccoa
Robert M. Harbin, Jr., Rome Allen M. Collinsworth, Atlanta
Charles L. Ridley, Jr., Macon Alfred M. Battey, Augusta
George R. Conner, Columbus

Public Relations

Chris J. McLoughlin, Atlanta, Chairman

Peter L. Scardino, Savannah Robert G. Ellison, Augusta
Thomas L. Ross, Jr., Macon Eugene L. Ward, Gainesville
J. Lamont Henry, Atlanta W. C. Cook, Columbus
Stephen D. Smith, Rome Geo. R. Dillinger, Thomasville

Cancer

J. E. Scarborough, Atlanta, Chairman

Hoke Wammock, Augusta Everett L. Bishop, Atlanta
David Henry Poer, Atlanta Thomas Harrold, Macon

SPECIAL COMMITTEES

(Appointed annually)

Medical Civil Preparedness

Edgar M. Dunstan, Atlanta, Chairman

C. A. Eberhart, Atlanta Perry P. Volpitto, Augusta
T. J. Ferrell, Waycross J. S. Skobba, Atlanta
Lee H. Battle, Jr., Rome Charles E. Dowman, Atlanta

American Medical Education Foundation

John L. Chandler, Jr., Augusta, Chairman

Edgar Woody, Jr., Atlanta, Co-Chairman

Robert R. McKnight, Augusta C. H. Richardson, Jr., Macon
James S. Holder, LaGrange Sage Harper, Douglas
Ernest F. Wahl, Thomasville C. H. Watt, Jr., Thomasville

Blood Banks

Warren B. Matthews, Atlanta, Chairman

George Dowling, Atlanta D. F. Mullins, Jr., Augusta
Walter L. Sheppard, Augusta F. H. Thompson, Albany
Lee Howard, Jr., Savannah John H. Venable, Atlanta
Mr. J. Y. Bowen, Griffin R. C. Williams, Atlanta

Abner Wellborn Calhoun Lectureship

Glenville Giddings, Atlanta, Chairman

Charles L. Prince, Savannah L. M. Freedman, Savannah
Henry H. Tift, Macon

RELATED COMMITTEES

Medical Advisory to Selective Service

William G. Hamm, Atlanta, Chairman

David Henry Poer, Atlanta, Co-chairman

Carter Smith, Atlanta S. A. Garrett, D.D.S., Atlanta
T. F. Sellers, Atlanta Chas. C. Rife, D.V.M., Atlanta
L. Minor Blackford, Atlanta Homer E. Nash, Atlanta
Cyrus W. Strickler, Jr., Atlanta Dana Hudson, R.N., Atlanta
A. O. Linch, Atlanta

First District Advisory Subcommittee

J. C. Metts, Savannah, Chm. Albert M. Deal, Statesboro
William H. Fulmer, Savannah Cleveland Thompson, Jr.,

K. C. Pendergrass, Americus
Enoch Callaway, LaGrange
W. F. Jenkins, Columbus
John Funke, Atlanta
John L. Barner, Athens
F. G. Eldridge, Valdosta
Lester Harbin, Rome

Lee Howard, Sr., Savannah
Neal F. Yeomans, Waycross
Kirk Shepard, Thomasville
Major F. Fowler, Atlanta
Wadley R. Glenn, Atlanta
John T. Mauldin, Atlanta

Rural Health

George T. Nicholson, Cornelia, Chairman

T. F. Sellers, Ex-Officio, Atlanta

1—Charles T. Brown, Guyton 6—W. A. Dodd, Wrightsville
2—W. B. Stoner, Sylvester 7—D. M. Cornett, LaFayette
3—M. F. Arnold, Hawkinsville 8—Hubert Milford, Hartwell
4—T. A. Sappington, Thos'ton 9—Joe J. Arrendale, Cornelia
5—James M. Combs, Atlanta 10—C. A. Wilson, Brunswick

Insurance Board

David R. Thomas, Jr., Augusta, Chairman

Charles S. Jones, Atlanta, Co-Chairman

W. L. Pomeroy, Waycross Luther H. Wolff, Columbus
D. Lloyd Wood, Dalton John L. Elliott, Savannah
Harry D. Pinson, Augusta Herbert M. Olnick, Macon

Veterans' Affairs

Hartwell Joiner, Gainesville, Chairman

A. R. Bush, Dublin Herbert S. Alden, Atlanta
A. O. Colquitt, Jr., Marietta C. C. Butler, Columbus
Bernard P. Wolff, Atlanta L. M. Freedman, Savannah
Charles R. Andrews, Canton Winston E. Burdine, Atlanta

Hospitals

Milford B. Hatcher, Macon, Chairman

H. Ansley Seaman, Waycross H. E. Weems, Perry
A. J. Davis, Augusta L. C. Yeargin, Dalton
H. A. Goodwin, Summerville W. B. Fackler, Jr., LaGrange
W. D. Hazlehurst, Macon Herbert D. Tyler, Thomaston
R. C. Williams, Atlanta, Rufus F. Payne, Augusta
Ex-Officio Robert Martin, III, Cuthbert
Ernest Thompson, Monroe

Chronic Illness

L. Minor Blackford, Atlanta, Chairman

E. F. Wahl, Thomasville A. Calhoun Witham, Augusta
Simone Brocato, Columbus J. B. Neighbors, Jr., Athens

Crawford W. Long Memorial

Lester Rumble, Jr., Atlanta, Chairman

Perry P. Volpitto, Augusta A. B. Boyd, Athens

Mental Health

Rives Chalmers, Atlanta, Chairman

J. R. Shannon Mays, Macon P. T. Scoggins, Commerce
Paul L. Schroeder, Atlanta Albert J. Kelley, Savannah
George H. Alexander, Forsyth T. J. VanSant, Jr., Marietta
Arthur M. Knight, Jr., Waycross Carl A. Whitaker, Atlanta
T. G. Peacock, Milledgeville, Consultant
Guy V. Rice, Atlanta, Consultant

Crippled Children

J. C. Hughston, Columbus, Chairman

Ruth M. Waring, Savannah James W. Bennett, Augusta
F. James Funk, Jr., Atlanta Harold W. Muecke, Waycross
John L. Chandler, Jr., Augusta

Third District Advisory Subcommittee

J. H. Robinson, III, Americus, Maurice F. Arnold, Jr.,
Chairman Hawkinsville
Charles E. McArthur, Cordele R. B. Martin, III, Cuthbert
Bon M. Durham, Americus Peter Graffagnino, Columbus
R. C. Pendergrass, Americus Luther H. Wolff, Columbus
L. C. Cheves, Montezuma Roy L. Gibson, Columbus
John E. Smith, Fitzgerald

Fourth District Advisory Subcommittee

J. W. Chambers, LaGrange, Douglas L. Head, Jr., Zebulon
Chairman H. C. King, Griffin
George P. Kinnard, Newnan William R. King, Jr., Griffin
J. H. Arnold, Newnan V. B. Williams, Griffin
K. D. Grace, LaGrange James A. Johnson, Jr.,
J. S. Holder, LaGrange Manchester

Fifth District Advisory Subcommittee

Robert W. Candler, Atlanta, Charles E. Dowman, Atlanta
Chairman Linton H. Bishop, Jr., Atlanta
Joseph C. Masee, Atlanta Edgar Boling, Atlanta
Edgar M. Dunstan, Atlanta T. E. McGeachy, Decatur
Sterling H. Jernigan, Atlanta William K. Kerr, Chamblee
H. H. Allen, Decatur

Sixth District Advisory Subcommittee

John A. Bell, Jr., Dublin, Frank Vinson, Fort Valley
Chairman Fred J. Coleman, Dublin
E. Y. Walker, Milledgeville J. P. Woodhall, Macon
O. C. Woods, Milledgeville W. K. Jordan, Macon
M. W. Hurt, Sandersville Henry H. Tift, Macon
J. R. S. Mays, Macon

Seventh District Advisory Subcommittee

John M. McGehee, Lester Harbin, Rome
Cedartown, *Chairman* John McCall, Rome
Roy Pope, Jr., Chickamauga Wm. B. Quillian, Cartersville
T. A. Cochran, Ringgold Alfred O. Colquitt, Jr.,
D. L. Wood, Dalton Marietta
Charles M. Garland, Jr., L. R. Lang, Calhoun
Smyrna

Eighth District Advisory Subcommittee

T. J. Ferrell, Waycross, *Chm.* S. T. Parkerson, McRae
A. G. Little, Jr., Valdosta J. B. Brown, Jr., Baxley
B. G. Owens, Valdosta J. W. Yeomans, Jesup
H. L. Moore, Brunswick Jesse L. Parrott, Hahira
Sage Harper, Douglas

Ninth District Advisory Subcommittee

Alex B. Russell, Winder, *Chm.* Chas. R. Andrews, Jr., Canton
O. C. Pittman, Commerce Joe J. Arrendale, Cornelia
John M. Hulsey, Jr., W. Bruce Schaefer, Toccoa
Gainesville W. Ben Nalley, Helen
Edward W. Grove, Gainesville C. J. Roper, Jasper
Robert T. Jones, III, Canton

Tenth District Advisory Subcommittee

M. C. Adair, Washington, M. A. Hubert, Athens
Chairman H. T. Kennedy, Warrenton
John B. O'Neal, III, Elberton Albert G. LeRoy, Thomson
H. L. Cheves, Union Point Lynn M. Huie, Monroe
A. S. Johnson, Sr., Elberton J. H. Nicholson, Madison

Augusta Advisory Subcommittee

C. G. Henry, Augusta, *Chairman*
John H. Sherman, Augusta W. K. Philpot, Augusta
C. M. Mulherin, Augusta G. L. Kelly, Augusta

Columbus Advisory Subcommittee

Luther H. Wolff, Columbus, *Chairman*
Roy Gibson, Columbus Polk Land, Columbus
Peter C. Graffagnino, S. A. Roddenbery, Columbus
Columbus

Macon Advisory Subcommittee

Willard R. Golsan, Macon, *Chairman*
Charles N. Wasden, Macon Harold C. Atkinson, Macon
John I. Hall, Macon Thomas L. Ross, Jr., Macon

Savannah Advisory Subcommittee

L. B. Dunn, Savannah, *Chairman*
T. A. McGoldrick, Savannah W. L. Osteen, Savannah
J. C. Metts, Savannah Jacob Rubin, Savannah

STATE BOARDS

State Board of Medical Examiners

(Meets in June and October)

Albert M. Deal, Statesboro, President—1959
Glenville Giddings, Atlanta, President-Elect—1957
Charles K. Wall, Thomasville—1959
Grady N. Coker, Canton—1956
Fred J. Coleman, Dublin—1956
Q. A. Mulkey, Millen—1957
R. H. McDonald, Newnan—1958
J. W. Palmer, Ailey—1958
Alex B. Russell, Winder—1958
L. N. Willis, Bainbridge—1959

State Board of Health

(Meets in April and October)

R. Lee Rogers, Gainesville, Chairman (9th District)—1956
J. M. Byne Jr., Waynesboro, Vice Chairman (1st District)—
1957
A. G. Funderburk, Moultrie (2nd District)—1957
O. C. Brannen, Columbus (3rd District)—1960
Virgil P. Williams, Griffin (8th District)—1961
Harold P. McDonald, Atlanta (5th District)—1960
A. M. Phillips, Macon (6th District)—1956
Fred H. Simonton, Chickamauga (7th District)—1956
C. J. Maloy, McRae (8th District)—1956
D. N. Thompson, Elberton (10th District)—1961

Georgia Dental Association Representatives

J. M. Hawley, Columbus—1958
J. G. Williams, Atlanta—1958

Georgia Pharmaceutical Association Representatives

J. B. Butts, Milledgeville—1959
W. W. Webb, Leslie—1959

State Medical Education Board

(Meets in June and October)

John W. Mauldin, Alma, Chairman—1957
J. Hubert Milford, Hartwell, Vice-Chairman—1957

C. L. Howard, Pelham—1957

H. Dawson Allen, Jr., Milledgeville—1955-57

Medical Examiners

State Board of Workmen's Compensation

Albert A. Rayle, Atlanta
Jack C. Norris, Atlanta
F. Kells Boland Jr., Atlanta
Marcus Mashburn Sr., Cumming
Hugh Hailey, Atlanta

Hospital Advisory Council

(Meets in April and October)

Representatives from Georgia Hospital Association

Mr. Oscar Hilliard, Fort Oglethorpe, Chairman—1956
Mr. Arthur T. Stewart, Greensboro—1955
Mr. George E. Linney, Americus—1957

Representatives, Medical Association of Georgia

H. Dawson Allen, Milledgeville—1956
J. T. McCall, Rome—1956
J. K. Quattlebaum, Savannah—1957
Joseph C. Read, Atlanta—1957
R. F. Spanjer, Cedartown—1955

Representative from the Georgia Dental Association

Thomas Conner, Atlanta—1957

Representative, Georgia Nursing Association

Miss Dana Hudson, Atlanta—1957

Representatives, State at Large

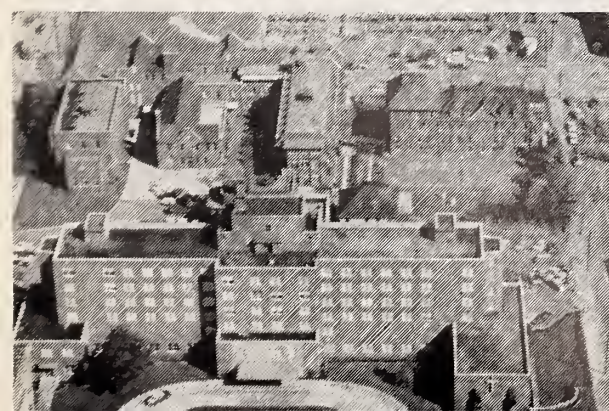
Mr. Walter Graefe, Griffin—1957
Mr. J. J. McLanahan, Elberton—1957
Mr. Frank A. Smith, Clayton—1956
H. C. Derrick, Lafayette—1959
Mr. H. Carson Smith, Lawrenceville—1959

Ex-Officio Members

T. F. Sellers, Director, State Health Department
Mr. Eugene Cook, Attorney General
Mr. Alan Kemper, Director, State Welfare Dept.
Mr. B. E. Thrasher, State Auditor



COME TO
THE 106TH
ANNUAL SESSION
Atlanta
May 13-16, 1956



This is an extremely sincere invitation
(Delivered with very sincere elation)
To come to the MAG Annual Session
(To keep in touch and prevent regression).

Back in Atlanta it is this year
(It's been four years since it was here),
And you'll notice a bit of difference in places
(Four hospitals alone have been changing their faces)

You're asked to come for four days in May
(You'd better reserve a room sans delay),
The Biltmore Hotel is the place to begin
(In the Crystal Lounge you must sign in).

Commercial exhibits will truly abound
(And detail men will show you around);
Scientific exhibits will be there too
(In the hope of teaching you something new).

The medical program is also supreme
(From the crop of speakers we'll have the cream);
Religion and law will be there too
(As they apply to your patients and you).

Most of the meetings are in the Hotel
(Consult The Program and you can tell);
The Academy of Medicine will also be used
(It's just a short walk, you can't be confused).

It's the social events that are scattered around
(Within the city and out of town),
But we know you can find them without any trouble
(If you study your map and then check double).

For most of the specialty luncheons
the Biltmore is the scene,
There service is stupendous
and the portions never lean.

But for doctors who are handy
with what's known as anesthesia,
The Naval O₂ Station
is a perfect place for leisure.

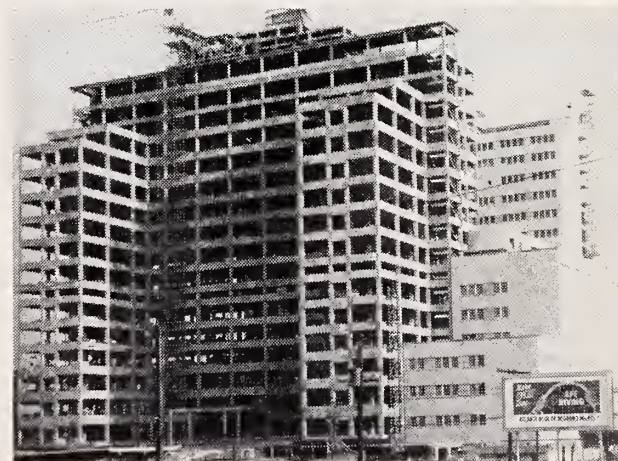
Stone Mountain will watch over
all the orthopedics men,
While they eat their Sunday suppers
from 7:30 till—when?

On Monday these same surgeons
will lunch downtown at 1:00,
The place is the Capital City Club
and the prospect is for fun.

The American College of Surgeons,
the Georgia Chapter, and wives
Will dine at Atlanta's Athletic Club
and, we hope, have the time of their lives.

Obstetricians and gynecologists
will jump with pure delight
At thoughts of the Piedmont Driving Club
for dinner on Monday night.

This tells you very little
of all there is in store
So read carefully The Program
and sign this on your door



ILLUSTRATIONS (reading clockwise)

Atlanta Biltmore Hotel
Commercial Exhibits
Piedmont Driving Club
Grady Memorial Hospital
Stone Mountain
St. Joseph's Infirmary
Piedmont Hospital
Capital City Club
Georgia Baptist Hospital
Academy of Medicine
Atlanta Athletic Club

**GONE TO
THE 106TH
ANNUAL SESSION
Atlanta
May 13-16, 1956**

OFFICIAL CALL

TO THE OFFICERS AND MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA:

THE 106TH ANNUAL SESSION of the Medical Association of Georgia will be held in Atlanta, Georgia, May 13-16, 1956.

The Official Registration Desk, located in the Crystal Lounge of the Atlanta Biltmore Hotel, will be opened for registration of MAG members and guests at 1:30 P. M. Sunday, May 13, and at 8:00 A. M. Monday and Tuesday, May 14 and 15. The desk will close at the end of the last meeting of the day.

The House of Delegates will convene at 5:00 P. M., Sunday, May 13, in the Auditorium of the Academy of Medicine, 875 West Peachtree Street, N.E.

The scientific sessions of the Association will open Sunday, May 13, with specialty section programs beginning at 2:15 P. M. Monday morning will be devoted primarily to general practitioners with a general session beginning at 8:00 A. M. The general session will be reconvened at 8:00 P. M. Monday for an evening program. The specialty sections will meet on Sunday, Monday, and Tuesday, May 13, 14, 15, as follows:

Sunday, May 13, 2:15 P. M.

Diseases of the Chest, Cardiology, Anesthesiology, and Radiology Joint Section
Pediatrics and E. E. N. T. Joint Section
Orthopedics Section

Monday, May 14, 2:15 P. M.

Industrial Surgery and Orthopedics Joint Section
Medicine and Diabetes Joint Section
Obstetrics and Gynecology Section
Anesthesiology Section
Radiology Section

Tuesday, May 15, 8:00 A. M.

Surgery Section
Medicine Section

Tuesday, May 15, 2:15 P. M.

Pathology Section

The president and other new officers will be installed at the MAG General Business Session, 10:30 A. M., Wednesday, May 16, 1956.

H. DAWSON ALLEN, JR., *President*

DAVID HENRY POER, *Secretary-Treasurer*

ANNUAL SESSION COMMITTEES

Local Arrangements Committee Fulton County Medical Society

Carl C. Aven, *General Chairman*
Bernard P. Wolff, *Co-Chairman*

E. Napier Burson, Jr.
J. Lamont Henry
Mrs. Robert Major, *MAG Auxiliary President*
Mrs. E. A. Bancker, *Auxiliary Convention Chairman*
J. H. Byram
Duncan Shepard
Mrs. A. H. Letton, *Fulton County Auxiliary President and Convention Co-Chairman*
Mrs. McClaren Johnson, *Auxiliary Convention Co-Chairman*

Advisory Committee

Mrs. Walker L. Curtis Mrs. Shelley C. Davis
Mrs. Bernard L. Shackelford Mrs. John W. Turner

Entertainment Committee

Murdock Eguen David E. Hein
Jack C. Norris

Finance Committee

Milton H. Freedman Harold P. McDonald

Visual Aid Committee

Joe S. Cruise A. Hamblin Letton

Publicity Committee

Christopher J. McLoughlin Philip H. Nippert

Meeting Room Arrangements

Ted F. Leigh

Auxiliary Liaison Committee

Don F. Cathcart Elizabeth Martin

Transportation Arrangements

J. G. McDaniel

Golf Committee

William E. Goodyear Harold P. McDonald

Hospitality Committee

Reese C. Coleman William A. Hopkins
William P. Leonard Lester Rumble, Jr.

Credentials Committee

(Tentative—to be confirmed)

Leo Smith, Waycross, *Chairman*
C. P. Savage, Montezuma, *Vice-Chairman*
Herbert Alden, Atlanta

Tellers Committee

(Tentative—to be confirmed)

Enoch Callaway, LaGrange, *Chairman*
William Harbin, Rome, *Vice-Chairman*
C. F. Holton, Savannah W. A. Selman, Atlanta

Reference Committees

(Tentative—to be confirmed)

Reference Committee No. 1

J. L. Walker, Clarkesville, *Chairman*
John Mooney, Statesboro, *Vice-Chairman*
E. C. McMillan, Macon, *Secretary*
W. W. Bryan, Atlanta J. M. Byne, Waynesboro
C. F. Holton, Savannah W. P. Martin, Summerville
Alex G. Little, Valdosta Virgil B. Williams, Griffin
Frank B. Schley, Columbus

Reference Committee No. 2

W. H. Fulmer, Savannah, *Chairman*
M. F. Simmons, Decatur, *Vice-Chairman*
W. P. Stoner, Sylvester, *Secretary*
R. L. Denney, Carrollton George M. Hutto, Columbus
A. G. LeRoy, Thomson R. C. Major, Augusta
J. W. Palmer, Ailey W. L. Pomeroy, Waycross

Reference Committee No. 3

Robert H. Vaughan, Columbus, *Chairman*
H. B. Cason, Warrenton, *Vice-Chairman*
Linton H. Bishop, Jr., Atlanta, *Secretary*
Rafe Banks, Gainesville Ralph Chaney, Augusta
T. J. Floyd, Jr., Griffin O. K. Coleman, Cordele
Samuel E. Patton, Macon W. C. Mitchell, Smyrna
D. N. Thompson, Elberton

Reference Committee No. 4

McClaren Johnson, Atlanta, *Chairman*
William Quillian, Cartersville, *Vice-Chairman*
George Wright, Augusta, *Secretary*
C. L. Ayers, Toccoa Charles T. Cowart, LaGrange
George R. Boyd, Clayton Oscar Mims, Thomasville
Milford B. Hatcher, Macon J. W. Yeomans, Jesup
Don Schmidt, Cedartown

Reference Committee No. 5

M. F. Arnold, Hawkinsville, *Chairman*
Lee Howard, Jr., Savannah, *Vice-Chairman*

Stephen Smith, Rome, *Secretary*

F. G. Eldridge, Valdosta James A. Green, Athens
A. A. McNeill, Camilla C. M. Mulherin, Augusta
J. H. Nicholson, Madison J. C. Patterson, Cuthbert
H. E. Weems, Perry

Reference Committee No. 6

B. L. Shackelford, Atlanta, *Chairman*
Glenn E. Seymour, Albany, *Vice-Chairman*
Fred H. Simonton, Chickamauga, *Secretary*
J. W. Chambers, LaGrange, *Ex-Officio*
Ruskin King, Savannah J. B. Mercer, Brunswick
R. C. McGahee, Augusta Roy Williams, Wadley

Reference Committee Alternates

James Bryant, Newnan P. B. Cleveland, Toccoa
M. M. Hagood, Marietta H. Hilt Hammett, LaGrange
Sage Harper, Douglas W. D. Hazlehurst, Macon
T. A. Peterson, Savannah R. H. Randolph, Athens
A. A. Rogers, Jr., Commerce C. K. Singleton, Cairo
H. W. Smith, Swainsboro David R. Thomas, Jr., Augusta
J. Frank Walker, Atlanta

SECTION OFFICERS

Georgia Society of Anesthesiologists

A. Jack Waters, Augusta, *President*
Lester Rumble, Jr., Atlanta, *Secretary*
Edwin L. Rushia, Augusta, *Program Chairman*

Georgia Chapter

American College of Chest Physicians
Clarence W. Mills, Jr., Atlanta, *President*
F. Levering Neely, Atlanta, *Secretary*
C. C. Aven, Atlanta, *Program Chairman*

Georgia Diabetes Association

Chris J. McLoughlin, Atlanta, *President and Program Chairman*
Alex T. Murphy, Augusta, *Secretary*

Georgia Academy of General Practice

W. G. Elliott, Cuthbert, *President*
Ben K. Looper, Canton, *Secretary*
John H. Hines, Roswell, *Program Chairman*

Georgia Heart Association

J. Lamont Henry, Atlanta, *President*
Goodloe Y. Erwin, Athens, *Secretary*
A. Park McGinty, Atlanta, *Program Chairman*

Georgia Industrial Surgeons Association

Allen M. Collinsworth, Atlanta, *President*
Charles S. Jones, Atlanta, *Secretary and Program Chairman*

Georgia State Obstetrical and Gynecological Society

O. R. Thompson, Macon, *President*
J. Lon King, Macon, *Secretary*
B. Hartwell Boyd, Atlanta, *Program Chairman*

Georgia Society of Ophthalmology and Otolaryngology

Alton V. Hallum, Atlanta, *President and Program Chairman*
W. P. Rhyne, Albany, *Secretary*

Georgia Orthopedic Society

William A. Newman, Macon, *President*
Robert R. McKnight, Augusta, *Secretary*
F. James Funk, Jr., Atlanta, *Program Chairman*

Georgia Association of Pathologists

Warren B. Matthews, Marietta, *President*
G. Darrell Ayer, Atlanta, *Secretary*
Everett L. Bishop, Atlanta, *Program Chairman*

Georgia Pediatrics Society

James P. Hanner, Atlanta, *President*
C. Dixon Fowler, Atlanta, *Secretary*
John T. Leslie, Decatur, *Program Chairman*

Georgia Fellows and Associates of The American College of Physicians

Carter Smith, Atlanta, *Governor*
A. Park McGinty, Atlanta, *Program Chairman*

Georgia Radiological Society

Neal F. Yeomans, Waycross, *President*
Bert H. Malone, Brunswick, *Secretary*
Robert M. Tankesley, Atlanta, *Program Chairman*

Georgia Chapter

American College of Surgeons

Enoch Callaway, LaGrange, *President*
Duncan Shepard, Atlanta, *Secretary and Program Chairman*

Georgia Trudeau Society

Sam E. Patton, Macon, *President*
John Bush, Columbus, *Secretary*
C. C. Aven, Atlanta, *Program Chairman*

Georgia Urological Society

John L. Stapleton, Columbus, *President*
C. M. Whitehead, LaGrange, *Secretary*
Harold P. McDonald, Atlanta, *Program Chairman*

VOTING RULES

1. By-Laws: Chapter V, Election of Officers:

Sec. 3. "One ballot shall be given to each voting member when he presents himself to cast his ballot. Such member and no other shall prepare his ballot and shall deposit it at that time in a locked ballot box provided by the Secretary-Treasurer and kept in the custody of the Tellers designated by the President. The key shall be kept by the Chairman of the Tellers.

Sec. 4. "Voting shall take place during the hours of the Scientific Program up to 10:30 a.m. of the last day of the annual session."

2. The names of qualified voters will be given to the person or persons in charge of the ballot box by the secretaries of the component county societies. If your name is not listed, see your county society secretary—he, *and he alone*, can make corrections.

3. The Tellers Committee will hear appeals from rules promptly each day of the Session. Appeals from committee rules may be made directly to members in general session.

4. No employee of the Association shall have any connection whatsoever with the ballot box or the voting, except to supply the Tellers Committee with essential information.

MEMBERS OF THE HOUSE OF DELEGATES

A preliminary roster of the legislative body of the Medical Association of Georgia

Delegates to the 106th Annual Session of the Medical Association of Georgia are listed below. Published in advance of the meeting, this list is subject to change.

ALTAMAHA (1)
 (Del) J. B. Brown, Baxley
 (Alt) A. P. Ohlmacher, Baxley

BALDWIN COUNTY (1)
 (Del) W. M. Scott, Milledgeville
 (Alt) Howard R. Cary, Milledgeville

BARTOW COUNTY (1)
 (Del) Wm. B. Quillian, Cartersville
 (Alt) W. B. Dillard, Jr., Cartersville

BEN HILL-IRWIN (1)
 (Del) H. L. Dismuke, Ocilla
 (Alt) Roy J. Johnson, Fitzgerald

BIBB COUNTY (6)
 (Del) W. W. Baxley, Macon
 Allan A. Cole, Macon
 M. B. Hatcher, Macon
 J. B. Kay, Byron
 E. C. McMillan, Macon
 Samuel E. Patton, Macon
 (Alt) George H. Alexander, Forsyth
 J. D. Applewhite, Macon
 W. D. Hazelhurst, Macon
 Wm. Earl Lewis, Macon
 Leon D. Porch, Macon
 Edwin R. Watson, Macon

BLUE RIDGE (1)
 (Del) James M. Burdine, Ellijay
 (Alt) R. A. Burns, Blue Ridge

BULLOCH-CANDLER-EVANS (1)
 (Del) John Mooney, Jr., Statesboro
 (Alt) L. H. Griffin, Claxton

BURKE COUNTY (1)
 (Del) J. M. Byne, Jr., Waynesboro
 (Alt) Cleveland Thompson, Jr., Waynesboro

CARROLL-DOUGLAS-HARALSON (2)
 (Del) C. H. Allen, Bremen
 R. L. Denney, Carrollton
 (Alt) T. M. Martin, Bowdon
 C. V. Vansant, Jr., Douglasville

CHATTAHOOCHEE (1)
 (Del) D. C. Kelley, Lawrenceville
 (Alt) R. E. Smith, Lawrenceville

CHATTOOGA COUNTY (1)
 (Del) W. P. Martin, Summerville
 (Alt) J. J. Allen, Trion

CHEROKEE-PICKENS (1)
 (Del) C. J. Roper, Jasper
 (Alt) Ben K. Looper, Canton

CLAYTON-FAYETTE (1)
 (Del) F. A. Sams, Jr., Fayetteville
 (Alt)

COBB COUNTY (2)
 (Del) M. M. Hagood, Marietta
 W. C. Mitchell, Smyrna
 (Alt) Bruce D. Burleigh, Marietta
 George Cauble, Acworth

COFFEE COUNTY (1)
 (Del) Sage Harper, Douglas
 (Alt) Thos. L. Parker, Douglas

COLQUITT COUNTY (1)
 (Del) P. D. Conger, Moultrie
 (Alt) John P. Tucker, Moultrie

COWETA COUNTY (1)
 (Del) James M. Bryant, Jr., Newnan
 (Alt) James H. Arnold, Newnan

CRAWFORD W. LONG (2)
 (Del) James A. Green, Jr., Athens
 R. H. Randolph, Athens
 (Alt) Marion A. Hubert, Athens
 A. Paul Keller, Jr., Athens

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 (Del) T. E. DuPree, Bainbridge
 (Alt) H. B. Baxley, Donalsonville

DEKALB COUNTY (2)
 (Del) W. A. Mendenhall, Chamblee
 M. F. Simmons, Decatur
 (Alt) L. C. Buchanan, Decatur
 G. L. Mitchell, Decatur

DOUGHERTY (2)
 (Del) J. Z. McDaniel, Albany
 Glenn E. Seymour, Albany
 (Alt)

ELBERT COUNTY (1)
 (Del) D. N. Thompson, Elberton
 (Alt) C. A. Mickel, Jr., Elberton

EMANUEL COUNTY (1)
 (Del) H. W. Smith, Swainsboro
 (Alt) H. R. Frost, Swainsboro

FLINT (1)
 (Del) O. K. Coleman, Cordele
 (Alt) O. T. Gower, Jr., Cordele

FLOYD COUNTY (2)
 (Del) Ralph N. Johnson, Rome
 Stephen D. Smith, Rome
 (Alt) E. L. Bosworth, Rome
 Robert F. Norton, Rome

FRANKLIN (1)
 (Del) J. Weldon Williams, Jr., Lavonia
 (Alt) S. D. Brown, Jr., Royston

FULTON COUNTY (28)
 (Del) Herbert S. Alden, Atlanta
 Thomas J. Anderson, Jr., Atlanta
 Carl C. Aven, Atlanta
 Linton H. Bishop, Jr., Atlanta
 Tully T. Blalock, Atlanta
 Edgar Boling, Atlanta
 W. W. Bryan, Atlanta
 James H. Byram, Atlanta
 Don F. Cathcart, Atlanta
 Hugh Hailey, Atlanta
 Alton V. Hallum, Atlanta
 William A. Hopkins, Atlanta
 McClaren Johnson, Atlanta
 J. Harry Lange, Atlanta
 Ted F. Leigh, Emory Univ.
 A. G. Linch, Atlanta
 Wood W. Lovell, Atlanta
 Harold P. McDonald, Atlanta
 Chris J. McLoughlin, Atlanta
 Marvin A. Mitchell, Atlanta
 Philip H. Nippert, Atlanta
 Jack C. Norris, Atlanta
 Purcell Roberts, Atlanta
 Lester Rumble, Jr., Atlanta
 B. L. Shackelford, Atlanta
 Charles F. Stone, Atlanta
 Cyrus Strickler, Jr., Atlanta
 J. Frank Walker, Atlanta
 (Alt) E. Napier Burson, Jr., Atlanta
 Amey Chappell, Atlanta
 J. J. Clark, Atlanta

William C. Coles, Atlanta
 George W. Fuller, Atlanta
 Harriet E. Gillette, Atlanta
 Daniel D. Hankey, Atlanta
 A. E. Hauck, Atlanta
 Byron J. Hoffman, Atlanta
 Joseph D. McElroy, Atlanta
 George A. Niles, Atlanta
 A. C. Richardson, Atlanta
 W. A. Selman, Atlanta
 Homer Swanson, Atlanta
 John H. Venable, Atlanta
 Margaret J. Wall, Atlanta
 Edgar Woody, Jr., Atlanta

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 (Del) John L. Elliott, Savannah
 W. H. Fulmer, Savannah
 Lee Howard, Jr., Savannah
 Ruskin King, Savannah
 T. A. Peterson, Savannah
 (Alt) W. O. Bedingfield, Savannah
 Allen W. Coward, Savannah
 O. H. Lott, Savannah
 Robert L. Oliver, Savannah
 J. H. Pinholster, Savannah

GLYNN COUNTY (2)
 (Del) J. B. Mercer, Brunswick
 Clyde A. Wilson, Jr., Brunswick
 (Alt) J. B. Avera, Brunswick
 Bert H. Malone, Brunswick

GORDON COUNTY (1)
 (Del) L. R. Lang, Calhoun
 (Alt) W. D. Hall, Calhoun

GRADY COUNTY (1)
 (Del) C. K. Singleton, Cairo
 (Alt) John A. Ferrence, Whigham

HABERSHAM COUNTY (1)
 (Del) Jesse L. Walker, Clarksville
 (Alt) Joe J. Arrendale, Cornelia

HALL COUNTY (2)
 (Del) Rafe Banks, Gainesville
 P. K. Dixon, Gainesville
 (Alt) W. R. Garner, Gainesville
 E. L. Ward, Gainesville

HART COUNTY (1)
 (Del) L. G. Cacchioli, Hartwell
 (Alt) J. H. Milford, Hartwell

JACKSON-BARROW (1)
 (Del) A. A. Rogers, Jr., Commerce
 (Alt) A. B. Russell, Winder

JASPER COUNTY (1)
 (Del) Marvin L. Greene, Monticello
 (Alt) J. H. Pritchett, Monticello

JEFFERSON COUNTY (1)
 (Del) C. Roy Williams, Wadley
 (Alt) J. J. Pilcher, Jr., Wrens

JENKINS COUNTY (1)
 (Del) A. P. Mulkey, Millen
 (Alt) Q. A. Mulkey, Millen

LAMAR COUNTY (1)
 (Del) J. H. Jackson, Barnesville
 (Alt) J. B. Crawford, Barnesville

LAURENS COUNTY (1)
 (Del) Mark Watkins, Dublin
 (Alt) Fred Coleman, Dublin

MCDUFFIE COUNTY (1)
 (Del) A. G. LeRoy, Thomson
 (Alt) Henry M. Althisar, Thomson

MERIWETHER-HARRIS (1)
(Del) W. P. Kirkland, Manchester
(Alt) H. Calvin Jackson, Manchester

MITCHELL COUNTY (1)
(Del) A. A. McNeill, Jr., Camilla
(Alt) L. E. Hackett, Camilla

MUSCOGEE COUNTY (4)
(Del) Roy L. Gibson, Columbus
 George M. Hutto, Columbus
 Frank B. Schley, Columbus
 Robert H. Vaughan, Columbus
(Alt) John K. Davidson, III, Columbus
 Polk S. Land, Columbus
 S. A. Roddenberry, Columbus
 Luther J. Roberts, Columbus

NEWTON COUNTY (1)
(Del) C. B. Palmer, Covington
(Alt) James Purcell, Calhoun

OCMULGEE (1)
(Del) M. F. Arnold, Hawkinsville
(Alt) D. H. Conner, Eastman

OCONEE VALLEY (1)
(Del) J. H. Nicholson, Madison
(Alt)

PEACH BELT (1)
(Del) H. E. Weems, Perry
(Alt) E. Faxton Seay, Marshallville

POLK COUNTY (1)
(Del) Don Schmidt, Cedartown
(Alt) Raymond F. Spanjer, Cedartown

RABUN COUNTY (1)
(Del) George R. Boyd, Jr., Clayton
(Alt) Robert T. Cain, Clayton

RANDOLPH-TERRELL (1)
(Del) J. C. Patterson, Cuthbert
(Alt) Charles Pugh, Lumpkin

RICHMOND COUNTY (7)
(Del) Stephen W. Brown, Augusta
 Thomas W. Goodwin, Augusta

R. C. Major, Augusta
 R. C. McGahee, Augusta
 C. M. Mulherin, Augusta
 David R. Thomas, Jr., Augusta
 George W. Wright, Augusta
(Alt)

SCREVEN (1)
(Del) Gerald B. Hogsette, Sylva
(Alt) James C. Freeman, Sylva

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(Del) F. G. Eldridge, Valdosta
 A. G. Little, Jr., Valdosta
(Alt) B. G. Owens, Valdosta
 E. F. Thompson, Sr., Valdosta

SOUTHEAST GEORGIA (1)
(Del) J. W. Palmer, Ailey
(Alt) C. W. Findley, Vidalia

SOUTHWEST GEORGIA (1)
(Del) J. B. Barton, Edison
(Alt) T. W. Rentz, Colquitt

SPALDING COUNTY (2)
(Del) T. J. Floyd, Jr., Griffin
 Virgil B. Williams, Griffin
(Alt) George L. Walker, Griffin

STEPHENS COUNTY (1)
(Del) Parish B. Cleveland, Toccoa
(Alt) Henry H. McNeeley, Toccoa

SUMTER COUNTY (1)
(Del) C. P. Savage, Montezuma
(Alt)

TATNALL COUNTY (1)
(Del) A. G. Pinkston, Glennville
(Alt) Louis R. Jelks, Reidsville

TAYLOR COUNTY (1)
(Del) R. C. Montgomery, Butler
(Alt) Lewis Beason, Butler

TELFAIR COUNTY (1)
(Del) C. J. Maloy, McRae
(Alt) Frank R. Mann, Sr., McRae

THOMAS-BROOKS (2)
(Del) Oscar M. Mims, Thomasville

John B. Morton, Thomasville
(Alt)

TIFT COUNTY (1)
(Del) T. L. Edmondson, Tifton
(Alt) W. L. Bridges, Jr., Tifton

TROUP COUNTY (2)
(Del) Charles T. Cowart, LaGrange
 Hilt H. Hammett, Jr., LaGrange
(Alt)

UPSON COUNTY (1)
(Del) T. A. Sappington, Thomas-ton
(Alt)

WALKER-CATOOSA-DADE (1)
(Del) Fred H. Simonton, Chickamauga

(Alt) Louis A. Williams, Ringgold

WALTON COUNTY (1)
(Del) Charles S. Floyd, Loganville
(Alt) Lynn M. Huie, Monroe

WARE COUNTY (2)
(Del) W. L. Pomeroy, Waycross
 Leo Smith, Waycross

(Alt) H. A. Seaman, Waycross
 Vilda Shuman, Waycross

WARREN COUNTY (1)
(Del) H. B. Cason, Warrenton
(Alt) A. W. Davis, Warrenton

WASHINGTON COUNTY (1)
(Del) O. D. Lennard, Tennille
(Alt) F. T. McElreath, Jr., Tennille

WAYNE COUNTY (1)
(Del) J. W. Yeomans, Jesup
(Alt) F. M. Harper, Jesup

WHITFIELD COUNTY (1)
(Del) Paul L. Bradley, Dalton
(Alt) David A. Wells, Dalton

WILKES COUNTY (1)
(Del) A. D. Duggan, Washington
(Alt) H. L. Cheves, Jr., Union Point

WORTH COUNTY (1)
(Del) W. P. Stoner, Sylvester
(Alt) H. G. Davis, Jr., Sylvester

IN MEMORIAM

WILEY A. ADERHOLD, Carrollton, September 11, 1955
 WILLIAM B. ARMSTRONG, Atlanta, December 2, 1955
 RUFUS A. ASKEW, Atlanta, July 5, 1955
 JOSEPH SIDNEY BEARD, Edison, June 2, 1955
 CHARLES DANIEL BOWDOIN, Atlanta, September 23, 1955
 JULIUS C. BURCH, Atlanta, October 23, 1955
 EMMETT ETHERIDGE BUTLER, Gainesville, May 5, 1955
 EDWIN S. BYRD, Atlanta, July 7, 1955
 W. L. CHAMPION, Atlanta, July 2, 1955
 WALLACE H. CLARK, LaGrange, August 30, 1955
 WILLIAM PETER COFFEE, Fitzgerald, February 7, 1956
 ALFRED TENNYSON COLEMAN, Dublin, September 2, 1955
 JOHN ALEXANDER CORRY, Barnesville, July 4, 1955
 WILLIAM FLETCHER FRIDDELL, Boston, October 9, 1955
 J. L. GARDNER, Sulphur Springs, August 28, 1955
 JOHN ELMO GARNER, Thomaston, January 24, 1956
 ROBERT B. GILBERT, SR., Greenville, August 16, 1955
 JOHN WILSON GOOD, Cedartown, December 19, 1955
 AUBREY HARPER, Wray, February 20, 1956
 HENRY TERRELL HARRISS, Washington, October 19, 1955
 CLAIR ABIE HENDERSON, Savannah, May 15, 1955
 HOWELL PARKS HOLBROOK, JR., Tucker, January 14, 1956
 EDGAR CASHION HOLMES, Moultrie, April 13, 1955
 HOLLIS F. HOPE, SR., Atlanta, November 2, 1955

MATTHEW K. JENKINS, Atlanta, February 6, 1956
 RANDALL P. KENDALL, JR., Columbus, May 7, 1955
 JACKSON WILEY LANDHAM, Atlanta, July 1, 1955
 HENRY GRADY LEE, Millen, December 26, 1955
 WILLIAM CULLEN McCARVER, Vidette, July 24, 1955
 JOHN WALTON McELROY, Ocilla, August 6, 1955
 J. M. McKENZIE, Thomaston, January 2, 1956
 OTTO WALTER (Tom) MEISSNER, Athens, Sept. 29, 1955
 LINUS J. MILLER, Atlanta, April 8, 1955
 FRANK BAXTER MITCHELL, SR., Crescent, July 3, 1955
 MALCOLM E. NOEL, Atlanta, February 15, 1956
 JOHN WESLEY ODEN, St. Petersburg, Fla., February 20, 1956
 JOHN JUDSON PILCHER, Wrens, January 14, 1956
 ALBERT W. REHBERG, Cairo, September 16, 1955
 O. L. ROGERS, Sandersville, January 10, 1956
 ATTICUS SAMUEL SANDERS, Lake Burton, February 14, 1956
 E. S. SANDERSON, Augusta, July 16, 1954
 ROBERT E. STEGALL, Moultrie, January 14, 1956
 RALPH L. TAYLOR, Davisboro, January 22, 1956
 THOMAS L. TIDMORE, Atlanta, February 5, 1956
 WILLIAM H. TRIMBLE, Atlanta, July 26, 1955
 JAMES REUBEN WALLIS, Lovejoy, September 18, 1955
 FORD WARE, Macon, October 4, 1955

ACHROM

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THE 106th ANNUAL

P.M. SUNDAY - MAY 13

2:15 SECTION MEETINGS

Diseases of the Chest, Cardiology, Anesthesiology, and Radiology Joint Section
*Exhibit Hall Meeting Room,
Atlanta Biltmore Hotel*

Pediatrics and E. E. N. T. Joint Section
Ballroom, Biltmore Hotel

Orthopedics Section
Room 2, Biltmore Hotel

4:30 MAG DELEGATES REGISTRATION

*Academy of Medicine, 875 West Peachtree
St., N. E.*

5:00 HOUSE OF DELEGATES MEETING

Academy of Medicine

6:30 SPECIALTY SOCIETY DINNERS

Ga. Soc. of Anesthesiologists
Ga. Soc. of Ophthalmology and
Otolaryngology
Am. College of Surgeons

7:30 Ga. Orthopedic Assn.
Ga. Pediatric Soc.
Am. College of Physicians

A.M. MONDAY - MAY 14

8:00 MAG REFERENCE COMMITTEES

No. 1, No. 2, No. 3
*MAG Headquarters Office,
Academy of Medicine*

8:00 ANESTHETIC STUDY COMMISSION MEETING

Room 6, Biltmore Hotel

8:00 RADIOLOGY BUSINESS MEETING

Room 10, Biltmore Hotel

8:00 GENERAL SESSION (G. P. DAY)

*Exhibit Hall Meeting Room,
Biltmore Hotel*

11:30 MAG GENERAL BUSINESS SESSION

*Exhibit Hall Meeting Room,
Biltmore Hotel*

P.M. MONDAY - MAY 14

1:00 SPECIALTY SOCIETY LUNCHEONS

Ga. Soc. of Anesthesiologists
Am. College of Chest Physicians
Ga. Trudeau Soc.
Ga. Diabetes Soc.
Ga. Academy of General Practice
Ga. Industrial Surgeons Assn.
Ga. State OB & GYN Soc.
Ga. Orthopedic Assn.
Ga. Radiological Soc.
Ga. Urological Assn.

2:15 MAG REFERENCE COMMITTEES

No. 4, No. 5, No. 6
*MAG Headquarters Office,
Academy of Medicine*

2:15 SECTION MEETINGS

Industrial Surgery and Orthopedics Joint
Section
Empire Room, Biltmore Hotel
Medicine and Diabetes Joint Section
Exhibit Hall Meeting Room, Biltmore Hotel
Obstetrics and Gynecology Section
Pompeian Room, Biltmore Hotel
Anesthesiology Section
Room 6, Biltmore Hotel
Radiology Section
Room 10, Biltmore Hotel
Urology Section
Mezzanine Lounge, Biltmore Hotel

6:00 SPECIALTY SOCIETY DINNER

Ga. State OB & GYN Soc.

7:30 GENERAL SESSION RECONVENED (G. P. DAY)

Ballroom, Biltmore Hotel

A.M. TUESDAY - MAY 15

8:00 SECTION MEETINGS

Surgery Section

Exhibit Hall Meeting Room, Biltmore Hotel

Medicine Section

Ballroom, Biltmore Hotel

10:00 GEORGIA ASSOCIATION OF PATHOLOGISTS BUSINESS MEETING

Mezzanine Lounge, Biltmore Hotel

12:00 FLOYD McRAE LECTURESHIP

Exhibit Hall Meeting Room, Biltmore Hotel

P.M. TUESDAY - MAY 15

1:00 SPECIALTY SOCIETY LUNCHEON

Ga. Assn. of Pathologists

2:15 HOUSE OF DELEGATES SECOND MEETING (RECESSED)

Academy of Medicine, 875 West Peachtree St., N. E.

2:15 SECTION MEETING

Pathology Section

Exhibit Hall Meeting Room, Biltmore Hotel

A.M. WEDNESDAY - MAY 16

10:30 MAG GENERAL BUSINESS SESSION

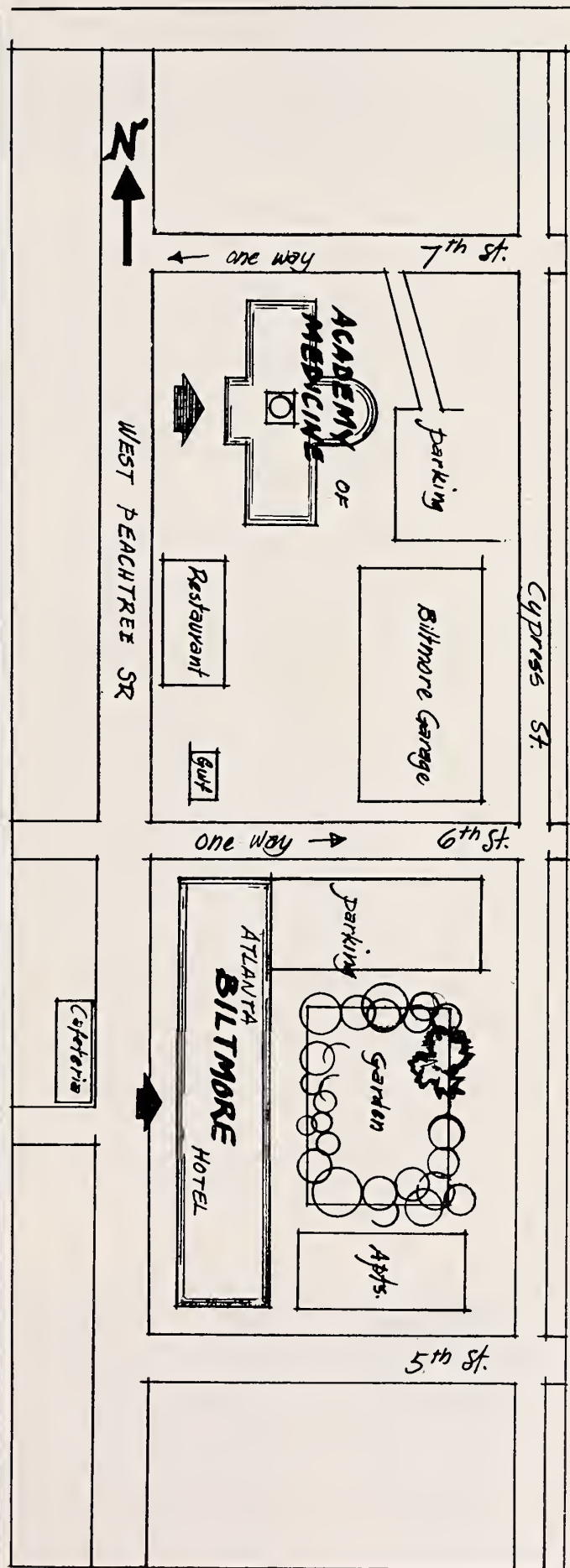
Exhibit Hall Meeting Room, Biltmore Hotel

11:30 NEW COUNCIL ORGANIZATIONAL MEETING

Exhibit Hall Meeting Room, Biltmore Hotel

11:30 MEETING OF 1957 PROGRAM CHAIRMEN

Exhibit Hall Meeting Room, Biltmore Hotel



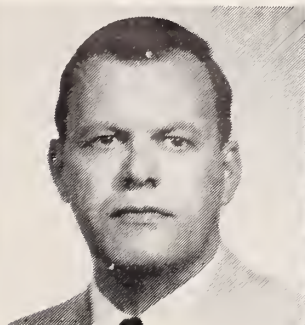
Annual Session Guest Speakers

THE 106TH ANNUAL SESSION of the Medical Association of Georgia will get off to a flying start on Sunday afternoon, May 13th, with two joint specialty section meetings: the Diseases of the Chest, Cardiology, Anesthesiology and Radiology Joint Section will meet at 2:15 in the Exhibit Hall Meeting Room of the Atlanta Biltmore Hotel; and the Pediatrics and Eye, Ear, Nose and Throat Joint Section will meet in the Ballroom of the Atlanta Biltmore Hotel beginning at the same time.

THOMAS FINDLEY, M. D., Augusta, will preside at the meeting of the Diseases of the Chest, Cardiology, Anesthesiology, and Radiology Joint Section. He will introduce the four guest speakers, C. RONALD STEPHEN, WENDEL G. SCOTT, JOHN W. KIRKLIN, and JOHN H. McCLEMENT, and act as moderator of the panel composed of these speakers on "The Management of Thoracic Diseases during the Surgical Period."

C. Ronald Stephen, Anesthesiologist

C. RONALD STEPHEN, M.D., the lead-off man in this section meeting, has been Professor of Anesthesia and Chief of the Division of Anesthesia of Duke Hospital and Duke University School of Medicine since 1950. A native of Canada, Dr. Stephen received his Bachelor of Science degree and his medical degree from McGill University. He received his D. A. degree from the Royal College of Physicians and Surgeons in London, England, in 1946, and became a diplomate of the American Board of Anesthesiology in 1950. Dr. Stephen was Director of Anesthesia at the Neurological Institute (Montreal) from 1946 through 1947; Director of the Department of Anesthesia at Children's Memorial Hospital (Montreal) from 1947-1950; and Assistant Professor of Anesthesia at McGill University from 1948-1950. Besides participating in the panel discussion on "The Management of Thoracic Diseases during the Surgical Period," Dr. Stephen will address the group on "Aspects of Chest Pathology Affecting Anesthesia." Comments will be made regarding the conduct of anesthesia in the presence of congenital heart disease. Mitral and aortic stenosis, coronary insufficiency, pulmonary hypertension, bronchiectasis, pulmonary fibrosis and emphysema, since, in the broad sense of the term, chest pathology includes both cardiac and pulmonary dysfunctions.



Dr. Stephen



Dr. Scott

On Monday, May 14, Dr. Stephen will be the guest of the Anesthesiologists at their section meeting. He will speak on "Hypoventilation and Hyperventilation in the Conduct of Anesthesia." With the increasing use during anesthesia of drugs which depress respiration either centrally or peripherally, the problem of hypoventilation, with its associated hypoxia and hypercarbia, has become of paramount importance. The dangers involved in hypoventilation and means of overcoming them will be stressed. Hypoventilation, as may be associated with controlled respirations, is assuming greater importance with the increasing reliance on muscle relaxant drugs and with the widening scope of thoracic surgery. Possible advantages and dangers seen with hyperventilation will be discussed.

Wendell G. Scott, Radiologist

THE SECOND PARTICIPANT in the panel on "The Management of Thoracic Diseases During the Surgical Period" in the meeting of the Diseases of the Chest, Cardiology, Anesthesiology, and Radiology Joint Section is WENDELL G. SCOTT, M.D., Associate Professor of Clinical Radiology, Washington University School of Medicine, St. Louis. Dr. Scott is also Associate Radiologist to Barnes and Allied Hospitals, a Consultant to the Veterans Administration and the Department of the Navy, Chairman of the Commission on Public Relations of the American College of Radiology, and Associate Editor of the *American Journal of Roentgenology*, *Radium Therapy* and *Nuclear Medicine*. The topic of his address to the joint section is "Angiocardiography and Aortography in the Diagnosis of Congenital Malformation of the Heart." The indications for angiocardiography and aortography will be briefly discussed and the limitations of these procedures pointed out. The technique of making these examinations will also be briefly described and a series of lantern slides of typical malformations shown.

On Monday, May 14, Dr. Scott will speak to the Radiology Section on the "Evaluation of Cobalt 60 and Cesium 137 for Telecurie Therapy." The advantages and disadvantages of these radioactive sources will be reviewed. Mention will also be made of their application for clinical therapy programs.

John W. Kirklin, Surgeon

THE THIRD SPEAKER, and also a panel participant, in the Diseases of the Chest, Cardiology, Anesthesiology, and Radiology Joint Section meeting on Sunday is JOHN W. KIRKLIN, M.D., Surgeon at the Mayo Clinic, Rochester, Minn., and Assistant Professor of Surgery, Mayo Foundation Graduate School, University of Minnesota. Dr. Kirklin is a graduate of the University of Minnesota, and he received his M.D. degree from Harvard Medical School in 1942. He interned at the Pennsylvania Hospital and has had post-graduate training in surgery at the Mayo Clinic and Children's Hospital

in Boston, Mass. He served two years in the U. S. Army Medical Corps during World War II and immediately thereafter. Besides participating in the panel discussion on Sunday afternoon, Dr. Kirklin will speak on "Indications for Cardiac Surgery." This will be a discussion of the heart and great vessels which are amenable to operation. Emphasis will be given to the indications for operations in these specific items.

On Monday, May 14, Dr. Kirklin will address the Medicine and Diabetes Joint Section on "The Problem of Pulmonary Hypertension in Surgical Treatment of Congenital Heart Disease." This will be concerned with pulmonary hypertension as it appears in various forms of congenital heart disease. The influence of this upon the prognosis of the patient with and without surgery will be discussed. The role of pulmonary hypertension in the mortality and results following corrective surgery will be outlined.

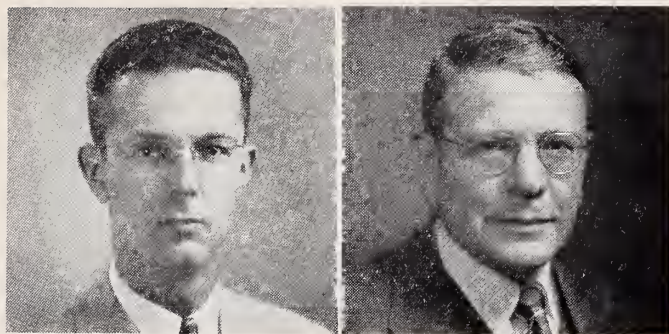
Dr. Kirklin will also speak to the Surgery Section at 10:15 on Tuesday morning, May 15. His topic will be "The Surgical Management of Bronchogenic Carcinoma"—a discussion of the classification of bronchogenic carcinoma as it applies to surgical therapy. The indications for and the technique of operation will be discussed. The results following surgery will be given.

John H. McClement, Internist

THE FOURTH AND FINAL SPEAKER of the Diseases of the Chest, Cardiology, Anesthesiology, and Radiology Joint Section meeting will be JOHN H. MCCLEMENT, M.D., Associate Professor of Medicine at the College of Physicians and Surgeons of Columbia University, New York, who will speak on "Use of Antibiotics in Pulmonary Disease." A native of New York State, Dr. McClement is a graduate of Syracuse University and the School of Medicine of the University of Rochester. He served his internship and residency at Peter Bent Brigham Hospital, Boston, and Bellevue Hospital in New York City. Since 1948, Dr. McClement has held various academic appointments in the department of medicine of the following schools: College of Physicians and Surgeons, Columbia University; Medical College of Cornell University; College of Medicine, University of Utah. Since June 1, 1955, he has also been Visiting Physician-in-Charge, Chest Service, Bellevue Hospital (Columbia University).

Jerome Glaser, Pediatrician

AT 2:15 SUNDAY AFTERNOON, May 13, in the Ballroom of the Atlanta Biltmore Hotel there will be a meeting of the Pediatrics and E. E. N. T. Joint Section over which JAMES P. HANNER, M.D., Atlanta, will preside. He will introduce as the first speaker, JEROME GLASER, M.D., Assistant Professor of Pediatrics at the University of Rochester School of Medicine and Dentistry. Dr. Glaser is a native of Pennsylvania and a graduate of Cornell University and Cornell University Medical School. He interned at Michael Reese Hospital in Chicago and served as assistant resident in Medicine (cancer research) at Barnes Hospital in St. Louis. Dr. Glaser was later resident pediatrician at the Sarah Morris Hospital for Children in Chicago and assistant resident at the Municipal Contagious Disease Hospital,



Dr. Kirklin

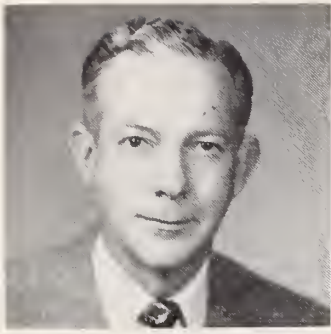
Dr. Glaser

Chicago. He practiced privately in Chicago before going to Europe for a year of graduate study in the pediatric clinics of Berlin and Vienna. He started his private practice of pediatrics and pediatric allergy in Rochester, N. Y., in 1929, and has limited his practice to pediatric allergy since 1951. In addition, Dr. Glaser is Pediatrician-in-Chief of the Genesee Hospital and Consulting Pediatrician, Rochester General and St. Mary's Hospitals, Rochester; Regional Consultant, the Jewish National Home for Asthmatic Children, Denver, Colo.; and Chairman, Section on Allergy of the American Academy of Pediatrics. Dr. Glaser is the author of a book published in February, 1956 entitled *Allergy in Childhood*. His topic for Sunday afternoon is "The Child With Frequent Colds." The child who has frequent colds is a very significant problem in pediatric practice. It is not commonly recognized that this condition is not infrequently of allergic origin. The differential diagnosis and treatment will be discussed.

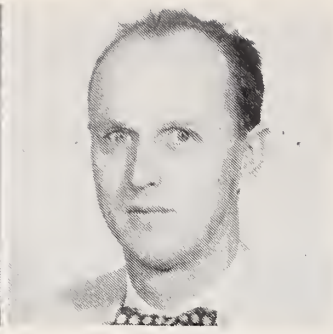
On Monday, May 14 (G. P. Day), Dr. Glaser will address the General Session on "Gastrointestinal Allergy in Infancy and Childhood." Gastrointestinal allergy may be defined as allergic reaction in the gastrointestinal tract. The term is not synonymous with "food allergy" since allergic disturbances of the gastrointestinal tract may occur to other substances than food, although this is rare in children. The first evidence of gastrointestinal allergy in the human being is commonly colic though by no means is all colic and probably not most infantile colic of allergic origin. Other gastrointestinal diseases of infancy and childhood which may at times be of allergic origin are discussed. These include pylorospasm, the celiac syndromes, ulcerative colitis, regional enteritis, cyclic vomiting, and geographical tongue.

Oliver W. Suehs, Otolaryngologist

OLIVER W. SUEHS, M.D., Austin, Texas, will address the Pediatrics and E. E. N. T. Joint Section, Sunday May 13, on "Secretory Otitis Media—Etiology, Diagnosis and Treatment." Since secretory otitis media is the most common cause of hearing loss in children it is a condition that physicians must be able to recognize and treat adequately if they are to prevent chronic adhesive otitis media with its resultant permanent hearing impairment. This paper will include a discussion of the incidence of this disease, the anatomical considerations that are significant in its pathogenesis, and a brief review of its pathology. The various causes of secretory otitis media will be reviewed, with particular attention given to the role played by sinusitis and by diseased tonsils and adenoids in children. Dr.



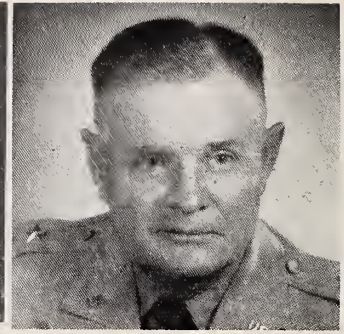
Dr. Suehs



Dr. Naquin



Dr. Ferguson



Maj. Gen. Hays

Suehs was born in Carmine, Texas, the son of a physician. He received his education in Austin public schools and at the University of Texas. He interned at the Graduate Hospital of the University of Pennsylvania, and served his residency in otolaryngology and broncho-esophagology at Jefferson Hospital, Philadelphia. He served in the Army 127th General Hospital in Europe for two years as Chief of the E. E. N. T. Section. Dr. Suehs is a diplomate of the American Board of Otolaryngology.

Howard Naquin, Ophthalmologist

HOWARD NAQUIN, M.D., Associate Professor of Ophthalmology, Johns Hopkins University School of Medicine, will speak to the Pediatrics and E. E. N. T. Joint Section on Sunday afternoon, May 13. His topic will be "Some Neuro-ophthalmological Syndromes in Childhood." A number of syndromes of particular interest to pediatricians and ophthalmologists will be discussed. Nevus flammeus (Sturge-Weber), arachnoidectyly and dislocated lenses (Marfan), hepatolenticular degeneration (Wilson's Disease), and amaurotic familial idiocy (Tay-Sachs Disease) will be considered. Clinical and pathological findings will be presented and management discussed. Dr. Naquin was born in Hawaii and received his secondary schooling there. He is a graduate of Leland Stanford University and Harvard Medical School, class of 1943. He served two years in the Medical Corps of the U. S. Navy and received post-graduate training at Boston City Hospital, Johns Hopkins Hospital, and Vanderbilt University Hospital. Dr. Naquin has been on the faculty of Johns Hopkins University School of Medicine since July 1, 1951, when he was appointed an Instructor in Ophthalmology; he has been an Associate Professor since 1954. Dr. Naquin is also Consultant in Ophthalmology and Chief-of-Service at Fort Howard Veterans Hospital.

Claude S. Hayes, Speech Correctionist

CLAUDE S. HAYES, Ph.D., Director of Education and Clinics of the Junior League School for Speech Correction, Atlanta, will speak to the Pediatrics and E. E. N. T. Joint Section when it meets on Sunday afternoon, May 13. Dr. Hayes' topic will be "Speech and Hearing Disorders: Diagnosis and Demonstration." For the information of those physicians unable to attend this meeting, Dr. Hayes and his assistant, Mrs. Kathryn B. Wall, are presenting an exhibit in booth 128 entitled "Diagnostic Services of the Junior League School for Speech Correction."

Albert B. Ferguson, Jr., Orthopedist

ALBERT B. FERGUSON, JR., M.D., Silver Associate Professor of Orthopedic Surgery at the University of Pittsburgh, will address the Orthopedics Section in Room 2, Atlanta Biltmore Hotel, on Sunday afternoon at 3:00. The topic of his talk will be "Etiology and Treatment of Juvenile Round Back." The evidence pointing out the possible etiologies of dorsal wedging round back including Schmorl's nodes, persistent vascular grooves, epiphyseal irregularity, and tight hamstrings will be reviewed.

On Monday, May 14, Dr. Ferguson will address the Industrial Surgery and Orthopedics Joint Section on "Epiphyseal Line Versus Fracture Line." Peculiar situations in which fracture lines are not readily recognized are not commonly known. The characteristics of the fracture line, where the epiphyseal line fracture actually is, fractures recognizable by soft tissue swelling alone, and birth fractures will be discussed. The characteristics of growth lines and anomalous bone development will be contrasted with trauma. Dr. Ferguson is eminently qualified to speak on these subjects. A native of New York, Dr. Ferguson graduated from Dartmouth College and Harvard Medical School, class of 1943. He was in training in Boston, at Children's Hospital, Peter Bent Brigham Hospital, and Massachusetts General Hospital, from 1943 through 1951 with the exception of two years' service with the U. S. Marine Corps (1944-46). He was a teaching fellow at Harvard University for a year before being made an Assistant in Orthopedic Surgery at Harvard University and Children's Hospital in Boston, and Junior Associate Orthopedic Surgeon at Peter Bent Brigham Hospital, Boston, in October, 1951. These positions he held until June, 1953, when he moved to Pittsburgh. Dr. Ferguson is Chief of Orthopedic Service at the University of Pittsburgh, and is on the Senior Staff of Children's Hospital, Presbyterian Hospital, and St. Margaret's Hospital, Pittsburgh. He is Chief Consultant of the VA Hospital there. Dr. Ferguson has had many articles published in national publications and was the editor of *Pediatric Clinics of North America* in the Fall of 1955. He is the author of *Orthopedic Surgery in Infancy and Childhood*, published by Williams and Wilkins, Baltimore, 1956.

Silas B. Hays, Army Surgeon General

AT THE HOUSE OF DELEGATES meeting on Sunday, May 13, at 5:00 MAJOR GENERAL SILAS B. HAYS, M.D., Surgeon General of the Army, will speak on "Military

Problems and the Civilian Physician." He will discuss the role of the civilian practitioner in Civil Defense and the handling of mass casualties; participation by the civilian physician in Reserve affairs and the influence on military medicine; the status of Dependent Medical Care and the effect on military and civilian physicians; and the utilization of doctors drafted into the military service and the need for career medical officers in the Army. General Hays was born in St. Paul, Minn., and attended public schools in the District of Columbia and West Chester, Pa. He attended Iowa State College and later the University of Iowa where he received his B.S. degree and, in 1928, M.D. degree. He was commissioned a first lieutenant, MC, in 1928 and was given a permanent commission in 1929 after interning for one year at Letterman General Hospital. General Hays has served in various medical capacities in this country, Hawaii, Europe and Japan. He was made Deputy Surgeon General in August, 1951, and succeeded Major General George E. Armstrong in the office of Surgeon General on June 1, 1955.

Edward S. Judd, Surgeon

TO START G. P. DAY, Monday, May 14, off with a bang, EDWARD S. JUDD, M.D., Associate Professor of Surgery of the Mayo Foundation, a branch of the University of Minnesota, will speak on "Surgical Aspects of Polyps of the Colon." Dr. Judd says that "as a preventive measure in attempting to improve the record in cancer of the colon, the surgeon should turn his efforts energetically toward early eradication of potentially serious disease. Isolated polyps of the colon are danger signals that indicate that this his colon is also capable of developing a cancer. A more radical attack upon the colon presenting isolated polyps is very much in order and can now be carried out much more safely. Multiple polyps of the familial variety will result in cancer in 100 per cent of the cases unless something drastic is done. Modern surgical methods make colectomy in one stage a very reasonable procedure and one that is followed by very satisfactory results."

On Tuesday, May 15, Dr. Judd will speak to the Surgery Section on "Papillary Carcinoma of the Thyroid." As a summary of his talk, Dr. Judd says, "Much of the confusion about the histopathology and mode of spread of this interesting lesion has now been dispelled. However, the inevitable result has been an argument concerning the degree of utilization required to achieve a satisfactory result. From a purely scientific standpoint, based on the treatment of a large number of patients, there are many occasions in children and young women where equally permanent cures can be derived from a less mutilating attack." Dr. Judd is a graduate of

Dartmouth College and Rush Medical College. He received the Master of Science degree in Surgery from the University of Minnesota. In addition to being Associate Professor of Surgery at the Mayo Foundation, he is a staff surgeon in the Mayo Clinic, where, with the exception of three years in the Army Medical Corps in World War II, he has been since 1942.

Francis D. W. Lukens, Internist

ALSO ADDRESSING THE G. P. Day General Session will be FRANCIS D. W. LUKENS, M.D., Philadelphia. Dr. Lukens is a graduate of the University of Pennsylvania School of Medicine, class of 1925. He is a permanent commissioned officer of the U. S. Public Health Service. Dr. Lukens is Associate Professor of Medicine of the University of Pennsylvania School of Medicine, Philadelphia. The topic of his address to the General Session is "Diagnosis of Diabetes." He will also speak to the Medicine Section on Tuesday, May 15, on "Adrenal Hyperfunction."

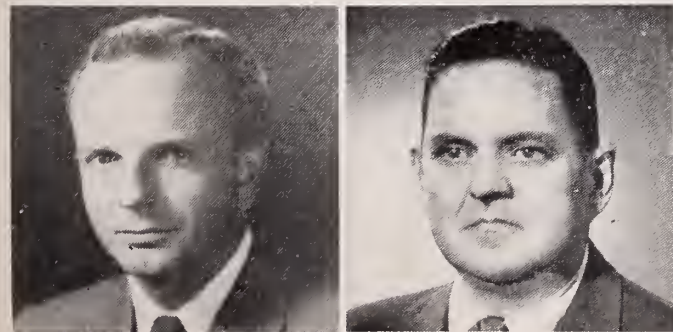
Isadore Dyer, Obstetrician

ISADORE DYER, M.D., New Orleans, is another featured speaker at the 106th Annual Session of the Medical Association of Georgia. Dr. Dyer is Professor of Obstetrics at Tulane University Medical School, and he is in charge of the Division of Obstetrics at Tulane University and the Tulane Obstetrical Unit at Charity Hospital in New Orleans. In summarizing his talk, "Mercurial Diuretics in Toxemia of Pregnancy: Use of a New Oral Mercurial Diuretic," to be given at the General Session on Monday, May 14, Dr. Dyer says, "Mercurial diuretic drugs have been employed as an adjunct to the established treatment of toxemias of pregnancy observed in the special clinics at Tulane. This latest, unpublished study will present the current regimen in use today as well as the detailed results obtained in treating this most common complication of pregnancy. The use of an oral mercurial diuretic has further aided in improving sodium excretion and regulating edema in both the ambulatory and hospitalized groups." Details of these observations will also be presented.

On the same day, Monday, May 14, Dr. Dyer will address the Obstetrics and Gynecology Section on "Total Hysterectomy at Cesarean Section and in the Immediate Post Partum Period." Dr. Dyer states that since May, 1949, total hysterectomy has been the procedure of choice in the Tulane service, whenever hysterectomy has been indicated in the puerperal period. This presentation will outline the present indications for this procedure, the surgical technique, and the results obtained since the original presentation of the subject in 1952. He will participate, with Robert J. Crossen and Richard Torpin, in a panel discussion in this meeting on "Obstetric and Gynecologic Problem Cases."

Robert J. Crossen, Gynecologist

IN ADDITION TO participating in the panel discussion in the Obstetrics and Gynecology Section meeting on Monday, May 14, ROBERT J. CROSSEN, M.D., Associate



Dr. Judd

Dr. Dyer



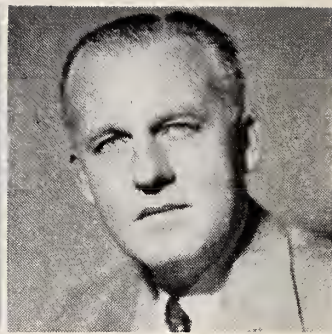
Dr. Crossen



Dr. Murray



Dr. Kessler



Dr. Kittredge

Professor of Clinical Gynecology and Obstetrics at Washington University Medical School, St. Louis, will present a paper on "Conization for Benign Lesions of Cervix—Question of Prophylactic Removal of Ovaries When a Hysterectomy Is Indicated." Dr. Crossen will review his personal experience with wide conization of the cervix over a period of 25 years, describing points in technique, methods of avoiding post-operative complications, and results in post conization deliveries. The question of whether or not both ovaries should be removed at the time of hysterectomy will be approached from the angles of development of inoperable ovarian carcinoma subsequent to hysterectomy with ovarian preservation, development of other conditions requiring subsequent removal of ovaries, better control of menopausal symptoms by salvaged ovary or by a known hormone level obtained by oral estrogens, and length of time that ovarian function continues after hysterectomy.

Dr. Crossen will speak to the G. P. Day General Session on Monday on "Cancer Prevention in Women;" at this time he will discuss the prevention of cervical cancer, endometrial cancer, ovarian cancer and vulvar cancer. Dr. Crossen is the author of *Diseases of Women, Synopsis for Gynecology*, and *Gynecology for Nurses*, and co-author of *Operative Gynecology*, Fifth Edition.

Dwight H. Murray, AMA President-Elect

AT THE MAG GENERAL BUSINESS SESSION on Monday afternoon, May 14, DWIGHT H. MURRAY, M.D., President-elect of the American Medical Association, will tell you about "Your AMA—Some Things to Expect in 1956." It is your AMA and for that reason it is a great privilege to have Dr. Murray come all the way from his home in Napa Calif., to speak at this meeting. Dr. Murray is a graduate of the Indiana University Medical School; he did post-graduate work at the University of Pennsylvania and the U. S. Naval Medical School. In 1922, following his discharge from the Navy Medical Corps, Dr. Murray started practicing medicine in Napa and he is at present chief of the medical staff of Parks Victory Memorial Hospital there. Dr. Murray has been president of his county medical society, a delegate to the California Medical Association and a delegate to the AMA from California. He was elected to the Board of Trustees of the AMA in 1945 and became its chairman in 1951. He was elected unanimously to serve as president-elect at the 104th Annual Meeting of the AMA held in June, 1955, at Atlantic City, N. J.

Henry Kessler, Rehabilitation Specialist

HENRY KESSLER, M.D., Newark, will address the Industrial Surgery and Orthopedics Joint Section on Monday, May 14, at 2:30. Dr. Kessler is a native of New Jersey and a graduate of Cornell University and Cornell University Medical College. He received his M.A. degree from Columbia University in 1932 and the Ph.D. degree from Columbia in 1934. Dr. Kessler is Medical Director of the Kessler Institute for Rehabilitation in West Orange, N. J., and Chief of the Medical Staff of the Hospital for Crippled Children, Newark. He is also on the staff of Beth Israel Hospital, Newark; Christ Hospital, Jersey City; and Hasbrouck Heights (N. J.) Hospital; and is Clinical Professor of Rehabilitation at the New York Medical College. The topic of Dr. Kessler's talk is "Rehabilitation: The New Look in Workmen's Compensation." Dr. Kessler has had vast experience in his field. He has surveyed the rehabilitation needs and facilities in Indonesia, Australia, New Zealand, Ceylon, Yugoslavia, Germany, Japan, the Philippines, Thailand, Italy, and Greece, and was appointed by the President of the United States to serve as official delegate to the International Congress of Industrial Accidents in Budapest, 1928; Geneva, 1931; Brussels, 1935, and Frankfurt, 1938. Dr. Kessler is also the author of several well known books on injury, disability and rehabilitation.

W. E. Kittredge, Urologist

W. E. KITTREDGE, M.D., New Orleans, will address the Urology Section on Monday, May 14. A native of Louisiana, he graduated from the Tulane University School of Medicine in 1933. He is now Associate Professor of Urology at Tulane University and has been a member of the staff of the Urology Department of the Ochsner Clinic since its inception in 1941. In his talk, "The Perineal Approach to the Prostate," Dr. Kittredge will discuss in detail the indications and advantages of the more modern method of perineal prostatectomy—both radical and subtotal—and the techniques described. A resume of his experience with perineal prostatic surgery will also be presented. Dr. Kittredge will preside over the Pyelogram Hour to be held during the same meeting.

Panelists—"Theology and Medicine"

TO PUT THE FINISHING TOUCHES on the G. P. Day, an evening general session has been planned for 7:30 on Monday, May 14. Ralph McGill, Editor of *The Atlanta Constitution*, will moderate a panel discussion



Mr. McGill

O. McClain, Atlanta; Robert B. Robins, M.D., Camden, Ark., and Raymond C. Cropper, Macon. Each one will give a brief presentation to be followed by a question and answer period. The emphasis in this program is on the "art of medicine" after spending the day on the "science of medicine."

RALPH MCGILL was born on a Tennessee farm "around the turn of the century" and graduated from Vanderbilt University. His college days were interrupted by service in the Marine Corps during World War I. He returned to Vanderbilt at the end of the war and it was then that his newspaper career began. He was a part-time police reporter with *The Nashville Banner*. After finishing school he was a sports reporter with the *Banner*. He came to *The Constitution* in 1928 and soon his colorful writing attracted nationwide comment. Awarded a Rosenwald fellowship for travel in Europe in 1938, Mr. McGill was in Vienna when Hitler invaded Austria. He came back to the editorship, but he refused to let his new responsibilities interfere with his penchant for getting around. He has been on the go almost constantly since, and we are very fortunate to have pinned him down for this assignment with the panel on religion and medicine.

THE REVEREND DAS KELLEY BARNETT is Associate Professor of Christian Ethics at the Episcopal Theological Seminary of the Southwest and Professor of Marriage and Morals at the University of Texas. Dr. Barnett is a graduate of Hardin-Simmons University; he received his degree of Doctor of Theology from the Southern Baptist Theological Seminary. He has done post-graduate work at the University of North Carolina and Columbia University and recently completed residence work for the Ph.D. degree at Yale University. Dr. Barnett's previous teaching assignments have been at Meredith College, Duke University and Mercer University; at Yale Divinity School he was graduate assistant to Richard Niebuhr, D.D.



Dr. Barnett



Dr. McClain

on "Theology and Medicine." Its purpose is to examine the essential points of rapport between religion and medicine, to point up the ways in which minister and physician and layman may supplement each other's efforts, to the end that the objectives of all may be better served. Panelists will include The Reverend Das Kelley Barnett, Austin, Texas; The Reverend Roy

THE REVEREND ROY O. MCCLAIN is pastor of the First Baptist Church in Atlanta. A native of Donalds, S. C., he is a graduate of Furman University and Southern Baptist Seminary (Th.M. and Th.D.). Dr. McClain is a member of the Board of Trustees of Shorter College, Rome, the Southern Baptist Radio and Television Commission, and is the current preacher for the Baptist Hour which is broadcast over 411 stations. He served with the U. S. Army as a chaplain with the rank of major in the Pacific Theatre of Operations.

ROBERT B. ROBINS, M.D., past president of the American Academy of General Practice, has not limited himself to the field of medicine, but has been active in politics and civic affairs. In 1952 he finished his second term as Democratic National Committeeman for the State of Arkansas and was the only physician on the National Committee. Dr. Robins is a graduate of Hendrix College and the University of Chicago where he received his M.D. and M.S. degrees. He is at present Chief-of-Staff of the Ouachita County Hospital and in practice at the Robins Clinic in Camden, Arkansas. He is also Professor of Medical Economics at the University of Arkansas School of Medicine.

RAYMOND C. CROPPER, Macon, is a businessman who has been very active in civic affairs for many years. Mr. Cropper is a native of Ohio; he came South in 1912 and located in Macon in 1920 where he founded the R. C. Cropper Company, a wholesale hardware and farm machinery firm. He has taught a Bible class at the Tattnall Square Presbyterian Church, where he is also an elder, for over 20 years. He is an active Rotarian and Mason, having been president of the Macon Rotary Club in 1941-42 and being at present Venerable Master of Scottish Rite Bodies in the Valley of Macon. In 1948 he was appointed to the Macon Hospital Commission, and in 1952 he was elected chairman of the Commission. He is also chairman of the Building Committee of the Macon hospital expansion program.

There are the ingredients of an ideal panel discussion on medicine and theology: a moderator with a vast storehouse of knowledge in many fields and a talent for ferreting out important points from masses of details and expressing them in everyday language, and four panelists: two theologians, a physician, and a businessman who have had experience in the fields of medicine and religion. Almost every physician in the Medical Association of Georgia has had a minimum of nine years' training in the science of medicine, let this be an introduction or refresher course in the art of medicine.



Dr. Robins



Mr. Cropper



Dr. Lull



Mr. Stetler

"The Physician in Court"

IMMEDIATELY FOLLOWING the panel discussion on Theology and Medicine, GEORGE F. LULL, M.D., will address the General Session on "The Physician in Court." Dr. Lull is Secretary and General Manager of the American Medical Association. A native of Pennsylvania, he received his M.D. degree from Jefferson Medical College in 1909. He holds the Doctor of Science degree from the Woman's Medical College of Philadelphia, the Master of Public Health degree from the Harvard School of Public Health and the degree of Doctor of Public Health from the University of Pennsylvania. He also has an honorary degree of LL.D. from Jefferson Medical College.

He entered the U. S. Army in 1912 and rose from the rank of First Lieutenant to that of Major General. After service in World War I he served as instructor at the Army Medical School and part time as Director of the Department of Preventive Medicine. From 1926 to January 1929 he served as Chief of the Statistical Division, Surgeon General's Office. From 1929 through 1932 he was detailed as Medical Advisor to the Governor-General of the Philippine Islands. In July 1940 he returned to duty in the office of the Surgeon General as Chief of the Military Personnel Division, and in June 1943 he was named Deputy Surgeon General of the U. S. Army, serving in that capacity until he joined the American Medical Association in January 1946, where he is now Secretary and General Manager.

At 8:40 P.M., C. JOSEPH STETLER, Chicago, will speak on "The Physician as a Medical Witness." Mr. Stetler is at present Director of the Law Department of the American Medical Association. He was formerly Secretary to the Council on National Emergency Medical Service and Secretary to the Committee on Legislation of the AMA. Mr. Stetler was born in Ohio and spent most of his early life in Fort Wayne, Indiana. He went to Washington, D. C., in 1935 to work with the Civil Service Commission. He has also worked with the Social Security Administration,

Veterans Administration, and with the War Claims Commission as Director of Legislation and Opinions Service.

At 9:00 P.M. a two-part mock trial of a personal injury case demonstrating the do's and don't's of medical expert testimony will be presented by staff members of the American Medical Association. The script is designed to stress the importance of cooperation between attorney and physician, adequate pre-trial conferences and understanding of the issues to be presented to and decided by the judge and jury.

The medical witness is portrayed in the first part of the demonstration as a physician who comes to court unprepared and with a misconception as to his role in the proceedings. The same witness is portrayed in the second part of the demonstration as a capable physician who on direct and cross-examination presents objective and factual testimony.

The medical witness will be RALPH E. DEFORREST, M.D., Secretary of the Council on Medical Physics, AMA. The attorneys conducting the examinations will be R. G. VAN BUSKIRK (direct examination) and EDWIN J. HOLMAN (cross-examination), staff members of the Law Department of the AMA. Mr. Stetler will act as presiding judge during the demonstration.

Dr. DeForest is a graduate of Wayne University College of Medicine and has done post-graduate work in orthopedic surgery and physical medicine at the Mayo Foundation and the University of Minnesota. He has been Secretary of the Council on Physical Medicine and Rehabilitation of the AMA since 1951.

Lemuel W. Diggs, Pathologist

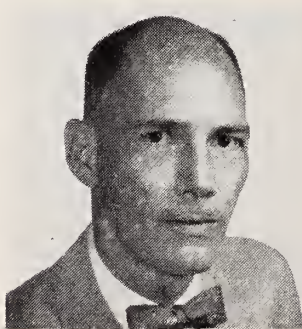
ON TUESDAY, MAY 15, LEMUEL W. DIGGS, M.D., of Memphis, Tenn., will address the Pathology Section on "The Management of Hemorrhagic Disease." Physicians in general practice and in every specialty encounter patients who have abnormal hemorrhagic phenomena and bleeding which is difficult to control. The basic facts concerning hemostatic and coagulation mechanisms will be discussed and points in practical management emphasized. Dr. Diggs is a graduate of Randolph-Macon College and Johns Hopkins University School of Medicine. He served his internship and residency at Strong Memorial Hospital, University of Rochester. He has been on the medical faculty of the University of Rochester and the University of Tennessee, where he has been Professor of Medicine since 1947. Dr. Diggs also held the position of Clinical Pathologist at the Cleveland Clinic Foundation from 1945-1947. Dr. Diggs is co-author of *Textbook of Clinical Pathology* and author of a book soon to be published entitled *Morphology of Human Blood Cells*. And he has contributed to many other works.



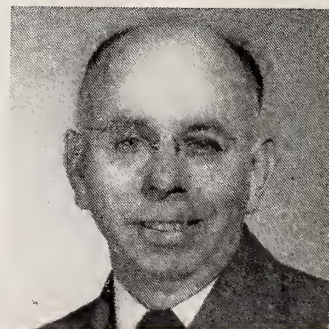
Dr. DeForest



Mr. Van Buskirk



Mr. Holman



Dr. Diggs

The Program

Sunday Morning, May 13

2:15 DISEASES OF THE CHEST, CARDIOLOGY, ANESTHESIOLOGY AND RADIOLOGY JOINT SECTION

(All Physicians Invited)

Exhibit Hall Meeting Room, Atlanta Biltmore Hotel

PRESIDING

Thomas Findley, Augusta

2:15 ASPECTS OF CHEST PATHOLOGY AFFECTING ANESTHESIA

C. Ronald Stephen, Durham, N. C.

2:35 ANGIOCARDIOGRAPHY AND AORTOGRAPHY IN THE DIAGNOSIS OF CONGENITAL MALFORMATIONS OF THE HEART

Wendell G. Scott, St. Louis, Mo.

2:55 INDICATIONS FOR CARDIAC SURGERY

John Kirklin, Rochester, Minn.

3:15 USE OF ANTIBIOTICS IN PULMONARY DISEASE

John H. McClement, New York, N. Y.

3:35 RECESS—VIEW EXHIBITS

3:45 PANEL: THE MANAGEMENT OF THORACIC DISEASES DURING THE SURGICAL PERIOD

MODERATOR

Thomas Findley, Augusta

PARTICIPANTS

C. Ronald Stephen, Durham, N. C.

Wendell G. Scott, St. Louis, Mo.

John Kirklin, Rochester, Minn.

John H. McClement, New York, N. Y.

ELECTION OF 1957 PROGRAM CHAIRMEN

2:15 PEDIATRICS AND E.E.N.T. JOINT SECTION (All Physicians Invited)

Ballroom, Atlanta Biltmore Hotel

PRESIDING

James P. Hanner, Atlanta

2:15 THE CHILD WITH FREQUENT COLDS*

Jerome Glaser, Rochester, N. Y.

**Presented in honor of the late Lewie D. Muse by Baker Laboratories.*

2:45 SECRETORY OTITIS MEDIA—ETIOLOGY, DIAGNOSIS AND TREATMENT

Oliver W. Suehs, Austin, Texas

3:15 SOME NEURO-OPHTHALMOLOGICAL SYNDROMES IN CHILDHOOD

Howard A. Naquin, Baltimore, Md.

3:45 DISCUSSION PERIOD (Questions and Answers)

4:00 SPEECH AND HEARING DISORDERS: DIAGNOSIS AND DEMONSTRATION

Claude S. Hayes, Ph.D., Atlanta, Director of Education, Junior League School for Speech Correction; and Kathryn B. Wall, M.A., Atlanta, Assistant Director of Education

ELECTION OF 1957 PROGRAM CHAIRMEN

2:15 ORTHOPEDICS SECTION

(All Physicians Invited)

Room 2, Atlanta Biltmore Hotel

PRESIDING

H. William Bondurant, Atlanta

2:15 A NEW SPLINT FOR MEDICAL TIBIAL TORSION

Walter P. Barnes, Jr., Macon

2:30 CONGENITAL DEFORMITIES OF THE HAND

J. Hiram Kite, Atlanta

3:00 ETIOLOGY AND TREATMENT OF JUVENILE ROUND BACK

Albert B. Ferguson, Jr., Pittsburgh, Pa.

3:30 SARCOMAS OF THE PELVIS

F. James Funk, Jr., Atlanta

3:50 HIP DISARTICULATION

Paul L. Reith, Warm Springs

ELECTION OF 1957 PROGRAM CHAIRMAN

4:30 MAG DELEGATES REGISTRATION

Academy of Medicine, 875 W. Peachtree St., N. E.

5:00 HOUSE OF DELEGATES MEETING

Academy of Medicine

PRESIDING

H. Dawson Allen, Jr., Milledgeville,

President, Medical Association of Georgia

ORDER OF BUSINESS

(See Delegates Handbook)

MILITARY PROBLEMS AND THE CIVILIAN PHYSICIAN

Major General Silas B. Hays, U. S. A., Washington, D. C., Surgeon General, Department of the Army

SPECIALTY SOCIETY DINNERS (Not a Part of Official Program)

Note: Make reservations in advance with chairmen if possible.

6:30 GEORGIA CHAPTER, AMERICAN COLLEGE OF SURGEONS (Wives Invited)

Atlanta Athletic Club, 166 Carnegie Way, N. W.

C. Richard King, Atlanta, Chairman

7:30 GEORGIA CHAPTER, AMERICAN COLLEGE OF PHYSICIANS AND GEORGIA HEART ASSOCIATION

Room 10, Atlanta Biltmore Hotel

A. Park McGinty, Atlanta, Chairman

6:30 GEORGIA SOCIETY OF ANESTHESIOLOGISTS

Naval Air Station, Chamblee

Lester Rumble, Jr., Atlanta, Co-chairman

6:30 GEORGIA SOCIETY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

Room 14, Atlanta Biltmore Hotel

Alton V. Hallum, Atlanta, Chairman

7:00 GEORGIA PSYCHIATRIC ASSOCIATION

Room 6, Atlanta Biltmore Hotel

Carl A. Whitaker, Atlanta, Chairman

7:30 GEORGIA ORTHOPEDIC ASSOCIATION

Howell Place, Stone Mountain

F. James Funk, Jr., Atlanta, Chairman

7:30 GEORGIA PEDIATRIC SOCIETY

Pompeian Room, Atlanta Biltmore Hotel

John T. Leslie, Decatur, Chairman

Monday Morning, May 14

G. P. Day

- 8:00 MAG REFERENCE COMMITTEES**
No. 1, No. 2, No. 3
MAG Headquarters Office, Academy of Medicine
- 8:00 ANESTHETIC STUDY COMMISSION MEETING**
(All Physicians Invited)
Room 6, Atlanta Biltmore Hotel
- 8:00 RADIOLOGY BUSINESS MEETING**
Room 10, Atlanta Biltmore Hotel
- 8:00 GENERAL SESSION (G. P. DAY)**
Exhibit Hall Meeting Room, Atlanta Biltmore Hotel
PRESIDING
W. G. Elliott, Cuthbert, President, Georgia Academy of General Practice
- 8:30 **SURGICAL ASPECTS OF POLYPS OF THE COLON**
Edward S. Judd, Rochester, Minn.
- 9:00 **DIAGNOSIS OF DIABETES**
Francis D. W. Lukens, Philadelphia, Pa.
- 9:30 **MERCURIAL DIURETICS IN TOXEMIA OF PREGNANCY: USE OF A NEW ORAL MERCURIAL DIURETIC**
Isadore Dyer, New Orleans, La.
- 10:00 **RECESS—VIEW EXHIBITS**
- 10:30 **CANCER PREVENTION IN WOMEN**
Robert J. Crossen, St. Louis, Mo.
- 11:00 **GASTROINTESTINAL ALLERGY IN INFANCY AND CHILDHOOD**
Jerome Glaser, Rochester, N. Y.
- 11:25 **ELECTION OF 1957 PROGRAM CHAIRMAN**
- 11:30 MAG GENERAL BUSINESS SESSION**
(All MAG and Auxiliary Members and Guests Invited)
Exhibit Hall Meeting Room, Atlanta Biltmore Hotel
PRESIDING
H. Dawson Allen, Jr., Milledgeville, President

- 11:30 **INVOCATION**
Rev. Edgar A. Padgett, Rector, Sardis Methodist Church, Atlanta
- 11:35 **ADDRESSES OF WELCOME**
Hon. William B. Hartsfield, Mayor of Atlanta
McLaren Johnson, Atlanta, President, Fulton County Medical Society
- 11:45 **YOUR AMA—SOME THINGS TO EXPECT IN 1956**
Dwight H. Murray, Napa, Calif., President-elect, American Medical Association
- 12:05 **PRESIDING**
R. C. McGahee, Augusta, First Vice-President
PRESIDENT'S ADDRESS
H. Dawson Allen, Jr., Milledgeville, President
NOMINATION OF OFFICERS
(Announcement of Tellers Committee)
President-Elect
First Vice-President
Second Vice-President
A.M. Delegate (Term beginning January 1, 1957)
A.M.A. Alternate Delegate (Term beginning January 1, 1957)
A.M.A. Delegate (Term beginning January 1, 1957)
A.M.A. Alternate Delegate (Term beginning January 1, 1957)
Councilor—Fifth District
Vice-Councilor—Fifth District
Councilor—Sixth District
Vice-Councilor—Sixth District
Councilor—Seventh District
Vice-Councilor—Seventh District
Councilor—Eighth District
Vice-Councilor—Eighth District

1:00 BALLOT BOX OPENS—location and rules posted on Official Bulletin Board — Vote Early

SPECIALTY SOCIETY LUNCHEONS (Not Part of Official Program)

Note: Make reservations in advance with chairman if possible.

- | | |
|--|--|
| 1:00 GEORGIA SOCIETY OF ANESTHESIOLOGISTS
<i>Room 6, Atlanta Biltmore Hotel</i>
Lester Rumble, Jr., Atlanta, Co-Chairman | 1:00 GEORGIA STATE OBSTETRICAL AND GYNCOLOGICAL SOCIETY
<i>Pompeian Room, Atlanta Biltmore Hotel</i>
Hartwell Boyd, Atlanta, Chairman |
| 1:00 GEORGIA CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS AND GEORGIA TRUDEAU SOCIETY
<i>Room 14, Atlanta Biltmore Hotel</i>
C. C. Aven, Atlanta, Chairman | 1:00 GEORGIA ORTHOPEDIC SOCIETY
<i>Capital City Club, 7 Harris St., N. W.</i>
F. James Funk, Jr., Atlanta, Chairman |
| 1:00 GEORGIA DIABETIC ASSOCIATION
<i>Atlanta Biltmore Hotel</i>
Chris J. McLoughlin, Atlanta, Chairman | 1:00 GEORGIA RADIOLOGICAL SOCIETY
<i>Room 10, Atlanta Biltmore Hotel</i>
Robert M. Tankesley, Atlanta, Chairman |
| 1:00 GEORGIA ACADEMY OF GENERAL PRACTICE
<i>Ballroom, Atlanta Biltmore Hotel</i>
John H. Hines, Roswell, Chairman | 1:00 GEORGIA UROLOGICAL ASSOCIATION (LUNCHEON AND BUSINESS MEETING)
<i>Mezzanine Lounge, Atlanta Biltmore Hotel</i>
Harold P. McDonald, Atlanta, Chairman |
| 1:00 GEORGIA INDUSTRIAL SURGEONS ASSOCIATION
<i>Empire Room, Atlanta Biltmore Hotel</i>
Charles S. Jones, Atlanta, Chairman | PRESIDING
John L. Stapleton, Columbus, President |

Monday Afternoon, May 14

2:15 MAG REFERENCE COMMITTEES

No. 4, No. 5, No. 6

MAG Headquarters Office, Academy of Medicine

2:15 INDUSTRIAL SURGERY AND ORTHOPEDICS JOINT SECTION

(All Physicians Invited)

Empire Room, Atlanta Biltmore Hotel

PRESIDING

Charles S. Jones, Atlanta

2:15 VASCULAR INJURIES IN INDUSTRY

Milton F. Bryant, Jr., Atlanta

2:30 REHABILITATION: THE NEW LOOK IN WORKMEN'S COMPENSATION

Henry H. Kessler, Newark, N. J.

3:15 SOFT TISSUE INJURIES OF THE HAND

John R. Lewis, Jr., Atlanta

3:30 DISABILITY FROM POWER LAWN MOWER INJURIES

John N. McClure, Atlanta

3:45 PRESIDING

F. James Funk, Jr., Atlanta

3:45 EPIPHYSEAL LINE VERSUS FRACTURE LINE

Albert B. Ferguson, Jr., Pittsburgh, Pa.

4:00 COMPLICATED FRACTURES OF THE FEMUR

Robert E. Wells, Atlanta

4:15 LACERATION OF DIGITS

Robert P. Kelly, Jr., Emory University

ELECTION OF 1957 PROGRAM CHAIRMEN

2:15 MEDICINE AND DIABETES JOINT SECTION

(All Physicians Invited)

Exhibit Hall Meeting Room, Atlanta Biltmore Hotel

PRESIDING

Christopher J. McLoughlin, Atlanta

2:15 INSULIN EDEMA

Dan Burge, Atlanta

2:30 EFFECTS OF EPINEPHRINE AND NOREPINEPHRINE ON CARBOHYDRATE METABOLISM

Walter L. Bloom, Atlanta

2:45 HYPOGLYCEMIA

Francis D. W. Lukens, Philadelphia, Pa.

3:15 RECESS—VIEW EXHIBITS

3:30 PRESIDING

J. Lamont Henry, Atlanta

3:30 THE PROBLEM OF PULMONARY HYPERTENSION IN SURGICAL TREATMENT OF CONGENITAL HEART DISEASE

John Kirklin, Rochester, Minn.

4:00 CARDIAC CATHETERIZATION AS AN AID IN MANAGEMENT OF THE CARDIAC PATIENT

Noble O. Fowler, Atlanta

4:15 ELECTROCARDIOGRAPHY: ITS PRESENT USES AND ABUSES

Bernard S. Lipman, Atlanta

ELECTION OF 1957 PROGRAM CHAIRMEN

2:15 OBSTETRICS AND GYNECOLOGY SECTION

(All Physicians Invited)

Pompeian Room, Atlanta Biltmore Hotel

PRESIDING

O. R. Thompson, Macon, President, Georgia State Obstetrical and Gynecological Society

2:15 FURTHER REPORT ON "NEW METHOD FRIEDMAN PREGNANCY TEST"

Jack C. Norris, Atlanta

2:30 TOTAL HYSTERECTOMY AT CESAREAN SECTION AND IN THE IMMEDIATE POST PARTUM PERIOD

Isadore Dyer, New Orleans, La.

3:00 CONIZATION FOR BENIGN LESIONS OF THE CERVIX—QUESTION OF PROPHYLACTIC REMOVAL OF OVARIES WHEN A HYSTERECTOMY IS INDICATED

Robert J. Crossen, St. Louis, Mo.

3:30 RECESS—VIEW EXHIBITS

3:45 PANEL: OBSTETRICAL AND GYNECOLOGICAL PROBLEM CASES

MODERATOR

William L. Caton, Atlanta

PANELISTS

Robert J. Crossen, St. Louis, Mo.

Isadore Dyer, New Orleans, La.

Richard Torpin, Augusta

ELECTION OF 1957 PROGRAM CHAIRMAN

2:15 ANESTHESIOLOGY SECTION

(All Physicians Invited)

Room 6, Atlanta Biltmore Hotel

PRESIDING

William H. Galvin, Emory University

2:15 HYPOVENTILATION AND HYPERVENTILATION IN THE CONDUCT OF ANESTHESIA

C. Ronald Stephen, Durham, N. C.

3:15 THE USE OF VINAMAR IN OBSTETRICS AND SHORT PROCEDURES

Frederick A. Carpenter, Emory University

3:45 FIVE YEARS' EXPERIENCE WITH RECTAL BARBITURATES IN PEDIATRIC ANESTHESIA

Margaret P. Peters, Atlanta, and Ann Wagar, Atlanta

4:15 BUSINESS MEETING—ELECTION OF OFFICERS AND 1957 PROGRAM CHAIRMAN

2:15 RADIOLOGY SECTION

(All Physicians Invited)

Room 10, Atlanta Biltmore Hotel

PRESIDING

Neal F. Yeomans, Waycross

2:15 EVALUATION OF COBALT 60 AND CESIUM 137 FOR TELECURIE THERAPY

Wendell G. Scott, St. Louis, Mo.

2:45 RADIOLOGICAL INVESTIGATION OF LARYNX AND PHARYNX

Brit B. Gay, Jr., and Joseph Chang, Emory University

3:15 THE USE OF ELECTRONIC IMAGE AMPLIFIERS IN CINEFLUOGRAPHY

H. Stephen Weens and Mr. John H. Tolan, Atlanta

ELECTION OF 1957 PROGRAM CHAIRMAN

2:15 UROLOGY SECTION

(All Physicians Invited)

Mezzanine Lounge, Atlanta Biltmore Hotel

PRESIDING

John L. Stapleton, Columbus, President Ga. Urological Society

2:15 THE PERINEAL APPROACH TO THE PROSTATE

W. E. Kittredge, New Orleans, La.

3:00 ANATOMY OF MALE PERINEUM (FILM)
Harold P. McDonald, Atlanta

3:30 PYELOGRAM HOUR
W. E. Kittredge, New Orleans, La.

Monday Night, May 14

SPECIALTY SOCIETY DINNER (Not Part of Official Program)

*Note: Make reservation in advance with
chairman if possible.*

6:00 GEORGIA STATE OBSTETRICAL AND GYNCO-
LOGICAL SOCIETY
*Piedmont Driving Club, 1215 Piedmont
Ave., N. E.*
Hartwell Boyd, Atlanta, Chairman

7:30 GENERAL SESSION RECONVENED (G. P. Day)
Ballroom, Atlanta Biltmore Hotel
PRESIDING

Maurice F. Arnold, Hawkinsville, President-
Elect, Georgia Academy of General Prac-
tice

7:30 PANEL: THEOLOGY AND MEDICINE
MODERATOR

Mr. Ralph McGill, Atlanta, Editor, *Atlanta
Constitution*

PANELISTS

Rev. Das Kelley Barnett, Austin, Texas
Mr. Raymond C. Cropper, Macon
Robert B. Robins, Camden, Ark.
Rev. Roy O. McClain, Atlanta

8:30 THE PHYSICIAN IN COURT

George F. Lull, Chicago, Secretary and Gen-
eral Manager, American Medical Associa-
tion

8:40 THE PHYSICIAN AS A MEDICAL WITNESS
Mr. C. Joseph Stetler, Chicago, Director,
A.M.A. Law Department

9:00 DEMONSTRATION OF EXPERT MEDICAL TESTI-
MONY

PARTICIPANTS

Mr. Stetler (presiding judge)
Ralph E. DeForest, Chicago, Secretary,
A.M.A. Council on Medical Physics (medi-
cal witness)

Mr. Edwin J. Holman, Chicago, Staff Mem-
ber, A.M.A. Law Department (defense at-
torney)

Mr. Richard G. Van Buskirk, Chicago, Staff
Member, A.M.A. Law Department (prose-
cuting attorney)

QUESTION AND ANSWER PERIOD
(Audience Participating)

Tuesday Morning, May 15

DON'T FORGET TO VOTE

8:00 SURGERY SECTION

(All Physicians Invited)

*Exhibit Hall Meeting Room, Atlanta Biltmore
Hotel*

PRESIDING

John M. Howard, Emory University

8:00 RECONSTRUCTION OF THE FACE FOLLOWING
TREATMENT OF CANCER

Frank F. Kanthak, Atlanta

8:30 BILIARY SURGERY: A 10 YEAR REVIEW OF
PRIVATE CASES

Albert L. Evans, Olin S. Cofer, Hugh H.
Gregory, and Guy L. Calk, Atlanta

9:00 PAPILLARY CARCINOMA OF THE THYROID
Edward S. Judd, Rochester, Minn.

9:45 THE MANAGEMENT OF ACUTE CHOLECYSTITIS
Charles S. Jones and John E. Skandalakis,
Atlanta

10:15 THE SURGICAL MANAGEMENT OF BRONCHOGENIC
CARCINOMA

John Kirklin, Rochester, Minn.

11:00 BREAST CANCER AS SEEN IN A STATE TUMOR
CLINIC

C. H. Richardson, Jr., and Calder B. Clay, Jr.,
Macon

ELECTION OF 1957 PROGRAM CHAIRMAN

8:00 MEDICINE SECTION

(All Physicians Invited)

Ballroom, Atlanta Biltmore Hotel

PRESIDING

McLaren Johnson, Atlanta

8:00 SKIN TEST REACTION PATTERNS IN ECZEMA
John L. Jacobs, Atlanta

8:15 BACK HALF HEADACHE
William R. Chambers, Atlanta

8:30 RADIOLOGIC DIAGNOSIS OF DUODENAL ULCER
Charles M. Silverstein, Atlanta

8:45 THE USE OF ANTI-CHOLINERGIC DRUGS IN THE
TREATMENT OF PEPTIC ULCER
John S. Atwater, Atlanta

9:00 DRUGS IN THE MANAGEMENT OF EMOTIONAL
PROBLEMS

Joseph S. Skobba, Atlanta

9:15 POSTURE AND PAIN
Harriet E. Gillette, Atlanta

9:30 PRACTICAL CONSIDERATIONS RELATIVE TO THE
ETIOLOGY AND TREATMENT OF HYPERTRO-
PHIC PULMONARY EMPHYSEMA

Osler A. Abbott, William E. Van Fleit, and
E. R. Duchesne, Emory University

9:45 RECESS—VIEW EXHIBITS

- 10:00 PRESIDING
Carter Smith, Atlanta
- 10:00 ADRENAL HYPERFUNCTION
Francis D. W. Lukens, Philadelphia, Pa.
- 11:00 SOME COMMENTS ON AUSCULTATION OF THE HEART
J. Willis Hurst, Emory University
- 11:15 VICTORIES OR VICTIMS: A CRITIQUE OF ADVANCES IN THE ANEMIAS
Claude-Starr Wright, Augusta
ELECTION OF 1957 PROGRAM CHAIRMAN

- 10:00 **GEORGIA ASSOCIATION OF PATHOLOGISTS BUSINESS MEETING**
Mezzanine Lounge, Atlanta Biltmore Hotel
- 12:00 **FLOYD McRAE LECTURESHIP (All Physicians Invited)**
Exhibit Hall Meeting Room, Atlanta Biltmore Hotel
- PRESIDING
Floyd W. McRae, Atlanta
SPEAKER TO BE ANNOUNCED

Tuesday Afternoon, May 15

SPECIALTY SOCIETY LUNCHEON (Not a Part of Official Program)

Note: Make reservations in advance with chairman if possible.

- 1:00 GEORGIA ASSOCIATION OF PATHOLOGISTS
Mezzanine Lounge, Atlanta Biltmore Hotel
Warren B. Matthews, Atlanta, Chairman

2:15 HOUSE OF DELEGATES SECOND MEETING (Recessed)

Academy of Medicine, 875 W. Peachtree St., N. E.

PRESIDING

Speaker of the House

- 2:15 ORDER OF BUSINESS
(See *Delegates Handbook*)

2:15 PATHOLOGY SECTION (All Physicians Invited)

Exhibit Hall Meeting Room, Atlanta Biltmore Hotel

PRESIDING

Everett L. Bishop, Atlanta

- 2:15 THE MANAGEMENT OF HEMORRHAGIC DISEASE
Lemuel W. Diggs, Memphis, Tenn.
QUESTION AND ANSWER PERIOD

Wednesday Morning, May 16

9:30 MAG GENERAL BUSINESS SESSION (All MAG and Auxiliary Members and Guests Invited)

Exhibit Hall Meeting Room, Atlanta Biltmore Hotel

PRESIDING

H. Dawson Allen, Jr., Milledgeville, President

PRESENTATION OF 50 YEAR CERTIFICATES

H. Dawson Allen, Jr., Milledgeville

PRESENTATION OF HARDMAN AWARD

Mr. Lamartine C. Hardman, Commerce

PRESENTATION OF CERTIFICATES OF APPRECIATION

David Henry Poer, Atlanta, Secretary-Treasurer

PRESENTATION OF SCIENTIFIC EXHIBIT AWARDS

Ted F. Leigh, Emory University, Chairman, Awards Committee

PRESENTATION OF PRESIDENT'S KEY
To Be Announced

PRESENTATION OF GOLF AWARDS

William E. Goodyear, Atlanta, Chairman, Golf Committee

SELECTION OF 1957 MEETING PLACE

ANNOUNCEMENT OF ELECTION RESULTS

Chairman, Tellers Committee

INSTALLATION OF NEW OFFICERS

ADJOURNMENT OF 106TH ANNUAL SESSION

11:30 NEW COUNCIL ORGANIZATIONAL MEETING

Exhibit Hall Meeting Room, Atlanta Biltmore Hotel

11:30 MEETING OF 1957 PROGRAM CHAIRMEN

Exhibit Hall Meeting Room, Atlanta Biltmore Hotel

The above papers are announced to be read before the scientific sessions. The order here is not necessarily the order that will be followed in the Official Program, and minor changes may be

required by conditions beyond the control of the MAG Committee on Scientific Work. Be sure to check your Official Program for final details.
Fred H. Simonton, Chickamauga, Chairman

Thirty-first Convention of the Woman's Auxiliary to the Medical Association of Georgia Atlanta, Georgia, May 13-16, 1956

President's Invitation

MEMBERS OF THE WOMAN'S AUXILIARY to the Medical Association of Georgia are called to convene in Atlanta on May 14, 1956. Registration will begin at the Atlanta Biltmore on Sunday, May 13. Meetings of the Auxiliary will be held in the auditorium of the Academy of Medicine, and a complete program of events is being announced. The Woman's Auxiliary to the Fulton County Medical Society is our hostess organization.

The wives of Medical Association of Georgia doctors are all cordially invited to attend this Thirty-first Annual Convention of the Auxiliary. There will be a fine opportunity for exchange of useful information as well as for pleasant visiting with each other.

Mrs. Robert C. Major
President, Woman's Auxiliary to
the Medical Association of
Georgia



Mrs. Major

Welcome to Atlanta

TO THE MEMBERS OF THE WOMAN'S AUXILIARY to the Medical Association of Georgia:

The Woman's Auxiliary to the Fulton County Medical Society and the City of Atlanta welcome you to the Thirty-first Annual Convention of the Woman's Auxiliary to the Medical Association of Georgia.

We have planned a full schedule of entertainment for your enjoyment, and hope that you will let us know if we can be of further service to you.

Sincerely,

Mrs. A. Hamblin Letton
President, Woman's Auxiliary to
the Fulton County Medical
Society



Mrs. Letton

ORGANIZATION

of the

Woman's Auxiliary to the Medical Association of Georgia

Officers, 1955-1956

President—Mrs. Robert C. Major	Augusta
President-Elect—Mrs. Walker L. Curtis	College Park
First Vice-President—Mrs. T. A. Sappington	Thomaston
Second Vice-President—Mrs. Ted F. Leigh	Atlanta
Third Vice-President—Mrs. Luther H. Wolff	Columbus
Recording Secretary—Mrs. Joe J. Arrendale	Cornelia
Corresponding Secretary—Mrs. Walter L. Sheppard	Augusta
Treasurer—Mrs. W. Loyd Osteen	Savannah
Historian—Mrs. Max Mass	Macon
Parliamentarian—Mrs. Ralph H. Chaney	Augusta

Advisory Committee

Dr. Shelley C. Davis, Chairman	Atlanta
Dr. W. Bruce Schaefer	Toccoa
Dr. W. G. Elliott	Cuthbert
Dr. Robert C. Major	Augusta
Dr. H. Dawson Allen, <i>ex-officio</i>	Milledgeville

Standing Committee Chairmen

Achievement Award—Mrs. D. L. Burns	Valdosta
American Medical Education Foundation— Mrs. Virgil Williams	Griffin
Archives—Mrs. Evert A. Bancker	Atlanta
Brawner Trophy—Mrs. Shelley C. Davis	Atlanta
Budget and Finance—Mrs. Leo Smith	Waycross
Bulletin—Mrs. W. P. Rhyne	Albany
By-Laws and Procedures—Mrs. W. Bruce Schaefer	Toccoa
Civil Defense—Mrs. J. M. Kellum	Thomaston
Doctors' Day—Mrs. Harold M. Smith	Savannah
Editorial—Mrs. Charles M. Huguley, Jr.	Atlanta
Legislation—Mrs. Edwin L. Rushia	Augusta
Mental Health—Mrs. R. M. Paty	Covington
Nurse Recruitment—Mrs. Phil Carroll Astin	Carrollton
Organization—Mrs. Walker L. Curtis	College Park
Program—Mrs. T. A. Sappington	Thomaston
Public Relations—Mrs. Edgar M. Dunstan	Decatur
Research and Romance of Medicine— Mrs. W. P. Stoner	Sylvester
Safety—Mrs. R. J. Mincey, Jr.	Thomaston
Scrap Book—Mrs. Luther H. Wolff	Columbus
Student Loan Fund—Mrs. William S. Boyd	Augusta
<i>Today's Health</i> —Mrs. Ted F. Leigh	Atlanta

Special Committee Chairmen

Hall of Fame—Mrs. Olin Cofer	Atlanta
State Hand Book—Mrs. Ralph Fowler	Marietta

District Managers

First District—Mrs. Louie H. Griffin	Claxton
Second District—Mrs. Fred Thompson	Albany
Third District—Mrs. O. T. Gower	Cordele
Fourth District—Mrs. T. A. Sappington	Thomaston
Fifth District—Mrs. Chris McLoughlin	Atlanta
Sixth District—Mrs. J. E. Lever	Sandersville
Seventh District—Mrs. Charles K. Richards	Calhoun
Eighth District—Mrs. Dan Jardine	Douglas
Ninth District—Mrs. Eugene L. Ward	Gainesville
Tenth District—Mrs. John L. Barner	Athens

County Auxiliary Presidents

Baldwin—Mrs. H. Dawson Allen, Jr.	Milledgeville
Bibb—Mrs. T. E. Rogers, Jr.	Macon
Bulloch-Candler-Evans—Mrs. John Daniel Deal	Statesboro
Calhoun-Early-Miller (Southwest Georgia)— Mrs. J. W. Merritt, Jr.	Colquitt
Carroll-Douglas-Haralson—Mrs. Floyd W. Morgan	Douglasville
Chatham (Aux. Georgia Medical Society)— Mrs. John E. Porter	Savannah
Chattooga—Mrs. W. U. Hyden	Trion
Cherokee-Pickens—Mrs. G. N. Coker	Canton
Cobb—Mrs. R. Y. Clark	Marietta

Coffee—Mrs. Calvin Meeks	Douglas
Crisp—Mrs. L. C. Wooten	Cordele
DeKalb—Mrs. M. F. Simmons	Decatur
Dougherty—Mrs. Fred H. Thompson	Albany
Elbert-Franklin-Hart—Mrs. D. N. Thompson	Elberton
Floyd—Mrs. Crawford Brock	Rome
Fulton—Mrs. A. H. Letton	Atlanta
Glynn—Mrs. Robert H. Thompson	Brunswick
Gordon—Mrs. R. D. Walter	Calhoun
Gwinnett—Mrs. Dan A. Martin	Lawrenceville
Habersham—Mrs. Joe J. Arrendale	Cornelia
Hall—Mrs. Ben Gilbert	Gainesville
Jackson-Barrow—Mrs. A. B. Russell	Winder
Lowndes-Lanier-Berrien-Cook-Clinch (South Georgia)— Mrs. V. C. Wade	Valdosta
Muscogee—Mrs. Charles R. Smith	Columbus
Newton-Rockdale—Mrs. F. C. Nesbit	Covington
Polk—Mrs. Don Schmidt	Cedartown
Randolph-Terrell—Mrs. Alphonso R. Sims	Richland
Richmond—Mrs. L. Q. Hair	Augusta
Stephens—Mrs. Henry H. McNeely	Toccoa
Sumter-Schley-Macon—Mrs. Russell Thomas	Americus
Thomas—Mrs. Roy F. Stinson	Thomasville
Tift—Mrs. C. S. Pittman	Tifton
Troup—Mrs. James C. Morgan, Jr.	West Point
Upson—Mrs. T. A. Sappington	Thomaston
Ware—Mrs. Samuel Victor	Waycross
Washington—Mrs. Joseph E. Lever	Sandersville
Whitfield—Mrs. A. M. Boozer	Dalton
Worth—Mrs. N. J. Crowe	Sylvester
Walker-Catoosa-Dade—Mrs. LeBron Alexander	Rossville

Past Presidents and Conventions

Honorary Presidents for Life

Mrs. James N. Brawner, Sr., Atlanta
Mrs. Eustace A. Allen, Atlanta

1924—Augusta (Organization)—Mrs. C. W. Roberts, Atlanta, Temporary Chairman
1925—Atlanta—Mrs. James N. Brawner, Sr., Atlanta
1926—Albany—Mrs. William H. Myers, Savannah
1927—Athens—Mrs. C. W. Roberts, Atlanta
1928—Savannah—Mrs. Paul Holiday (Mrs. J. C. Moore, Gaff- ney, S.C.)
1929—Macon—Mrs. Charles C. Hinton, Macon
1930—Augusta—Mrs. Marion T. Benson, Atlanta
1931—Macon—Mrs. Charles C. Harrold, Macon
1932—Savannah—Mrs. Ralston Lattimore, Savannah
1933—Macon—Mrs. S. T. R. Revell, Louisville
1934—Augusta—Mrs. J. Bonar White, Atlanta (Deceased)
1935—Atlanta—Mrs. J. E. Penland, Waycross
1936—Savannah—Mrs. Ernest R. Harris, Winder
1937—Macon—Mrs. W. R. Dancy, Savannah
1938—Augusta—Mrs. Ralph Chaney, Augusta
1939—Atlanta—Mrs. Warren A. Coleman, Eastman
1940—Savannah—Mrs. Eustace A. Allen, Atlanta
1941—Macon—Mrs. H. G. Bannister, Ila
1942—Augusta—Mrs. Lee Howard, Savannah
1943—Atlanta—Mrs. J. Lon King, Macon
1944—Savannah—Mrs. Olin S. Cofer, Atlanta
1945—No convention
1946—Macon—Mrs. W. T. Randolph, Winder
1947—Augusta—Mrs. W. Bruce Schaefer, Toccoa
1948—Atlanta—Mrs. W. G. Elliott, Cuthbert
1949—Savannah—Mrs. S. A. Anderson, Atlanta
1950—Macon—Mrs. J. Harry Rogers, Atlanta
1951—Augusta—Mrs. Lehman W. Williams, Savannah
1952—Atlanta—Mrs. J. R. S. Mays, Macon
1953—Savannah—Mrs. Ralph Fowler, Marietta
1954—Macon—Mrs. Leo Smith, Waycross
1955—Augusta—Mrs. Shelley C. Davis, Atlanta

Convention Arrangements Committee

Woman's Auxiliary to the Fulton County Medical Society

Mrs. Evert A. Bancker, *General Chairman*

Mrs. McClaren Johnson, *General Co-chairman*

Mrs. A. Hamblin Letton, *General Co-chairman*

Advisory Committee

Mrs. Walker L. Curtis
Mrs. Bernard L. Shackelford

Mrs. Shelley C. Davis
Mrs. John W. Turner

Credentials and Registration

Mrs. Allen H. Bunce, *Chairman*

Mrs. Dick R. Longino, *Co-chairman*

Mrs. L. C. Antrobus
Mrs. Guy Hewell

Mrs. Edward L. Askren, Jr.
Mrs. H. Walker Jernigan

Mrs. Max M. Blumberg
Mrs. Clifton G. Kemper

Mrs. Ben Hill Clifton
Mrs. A. O. Linch

Mrs. Arthur J. Crumbley
Mrs. John Ross McCain

Mrs. T. F. Davenport
Mrs. Dan Y. Sage

Mrs. W. Beecher Duvall
Mrs. W. P. Sloan, Sr.

Mrs. S. Ross Brown
Mrs. Henry E. Steadman

Mrs. Major F. Fowler
Mrs. Exum Walker

Display and Meeting Rooms

Mrs. Tully T. Blalock, *Chairman*

Mrs. Robert F. Mabon, *Co-chairman*

Mrs. Hartwell Boyd
Mrs. Albert A. Rayle, Jr.

Mrs. Wm. R. Crowe
Mrs. Lester Rumble, Jr.

Mrs. Mason Lowance
Mrs. William G. Whitaker, Jr.

Executive Board Meetings

Mrs. Harold P. McDonald, *Chairman*

Mrs. James H. Byram, *Co-chairman*

Mrs. Needham Bateman
Mrs. E. A. Dunbar

Mrs. Guy Chelton
Mrs. W. H. Grimes, Jr.

Mrs. D. B. Dennison
Mrs. Joseph L. Kurtz

Flowers

Mrs. August B. Turner, *Chairman*

Mrs. Thomas L. Tidmore, *Co-chairman*

Mrs. Thomas J. Anderson
Mrs. A. V. Gude

Mrs. John J. Barnes
Mrs. Stewart Long

Mrs. Linton H. Bishop
Mrs. Wood W. Lovell

Mrs. Richard E. Boger
Mrs. W. Spence McClelland

Mrs. Dan Burge
Mrs. David S. McKee

Mrs. Sandy B. Carter
Mrs. Wyman P. Sloan, Jr.

Mrs. George R. Gish, Jr.
Mrs. J. Frank Walker

Hospitality

Mrs. A. Worth Hobby, *Chairman*

Mrs. Edgar M. Dunstan, *Co-chairman*

Mrs. Milton T. Edgerton, *Co-chairman*

Mrs. Eustace A. Allen
Mrs. Haywood N. Hill

Mrs. Sam A. Anderson
Mrs. George F. Klugh

Mrs. Marion T. Benson, Sr.
Mrs. R. Bruce Logue

Mrs. Maxwell Berry
Mrs. John T. Mauldin

Mrs. James N. Brawner, Sr.
Mrs. J. Calhoun McDougall

Mrs. Samuel Y. Brown
Mrs. Chris McLoughlin

Mrs. Stephen T. Brown
Mrs. C. A. Rhodes

Mrs. John D. Campbell
Mrs. Charles Rieser

Mrs. Don F. Cathcart
Mrs. C. W. Roberts

Mrs. H. C. Crawford
Mrs. J. Harry Rogers

Mrs. W. W. Daniel
Mrs. W. A. Selman

Mrs. M. Bedford Davis, Jr.
Mrs. W. A. Smith

Mrs. William T. Edwards
Mrs. Scott L. Tarplee

Mrs. George W. Fuller
Mrs. John W. Thompson

Mrs. Thomas P. Goodwyn
Mrs. J. C. Thoroughman

Mrs. Edgar H. Greene
Mrs. Julian Q. Watters

Luncheon and Fashion Show

Mrs. Byron F. Harper, *Chairman*

Mrs. William R. Chambers, *Co-chairman*

Mrs. John T. Akin
Mrs. James T. King

Mrs. Reese C. Coleman, Jr.
Mrs. J. Harry Lange

Mrs. Richard A. Elmer
Mrs. Jack C. Norris

Mrs. L. Harvey Hamff
Mrs. Edgar D. Shanks, Jr.

Mrs. Robert E. Huie
Mrs. Homer S. Swanson

Pages

Mrs. Olin S. Cofer, *Chairman*

Mrs. J. K. Fancher, *Co-chairman*

Mrs. L. C. Antrobus
Mrs. Brit B. Gay, Jr.

Mrs. C. Raymond Arp
Mrs. Lamar F. Glass

Mrs. Pierce Allgood
Mrs. Hugh H. Gregory

Mrs. J. Gordon Brackett
Mrs. Thomas N. Guffin

Mrs. Napier Burson
Mrs. David L. Hearin

Mrs. Ellsworth Cale
Mrs. Richard King

Mrs. Guy L. Calk
Mrs. Sterling Richardson

Mrs. C. Walter Coolidge
Mrs. Herbert L. Shessel

Mrs. Gregory E. Flynn
Mrs. Charles E. Todd, Jr.

Mrs. F. James Funk, Jr.
Mrs. John P. Wilson

Publicity

Mrs. J. Luther Clements, Jr., *Chairman*

Mrs. John O. Ellis, *Co-chairman*

Mrs. Charles E. Brown
Mrs. Hal Henschen

Mrs. W. J. Fedack

Past Presidents' Luncheon

Mrs. F. Kells Boland, Jr., *Chairman*

Mrs. Ted F. Leigh, *Co-chairman*

Mrs. William A. Hopkins
Mrs. Sam A. Wilkins, Jr.

Mrs. Charles M. Huguley, Jr.

President's Banquet

Mrs. Bernard L. Shackelford, *Liaison Member*

Tea

Mrs. Murdock Equen, *Chairman*

Mrs. Hal Davison, *Co-chairman*

Mrs. W. W. Anderson
Mrs. Ralph A. Murphy, Jr.

Mrs. John S. Atwater
Mrs. Michael V. Murphy, Jr.

Mrs. Walter Holmes
Mrs. Hines Roberts

Mrs. Lon Grove
Mrs. Carter W. Smith

Mrs. William G. Hamm
Mrs. C. W. Strickler, Jr.

Mrs. James P. Hanner
Mrs. Bernard P. Wolff

Mrs. William C. Hathcock
Mrs. Gratton C. Woodson, Jr.

Telephone

Mrs. Arthur A. Smith, *Chairman*

Mrs. James C. Tanner, *Co-chairman*

Mrs. J. Frank Arthur
Mrs. Daniel D. Hankey

Mrs. Charles Eberhart
Mrs. Thomas A. Harris

Mrs. Henry Finch
Mrs. Ralph L. Robinson

Mrs. C. Dixon Fowler
Mrs. James V. Rogers, Jr.

Mrs. C. Stedman Glisson
Mrs. H. L. Teate, Jr.

Transportation

Mrs. Jeff L. Richardson, *Chairman*

Mrs. Charles P. Yarn, *Co-chairman*

Mrs. James N. Brawner, Jr.
Mrs. Arthur Merrill

Mrs. Taylor Burgess
Mrs. Martin Myers

Mrs. Russell Burke
Mrs. Vernon Powell

Mrs. Rives Chalmers
Mrs. Marion C. Pruitt

Mrs. John B. Cross
Mrs. Ben S. Read

Mrs. Roger W. Dickson
Mrs. Joseph C. Read

Mrs. Mark Dougherty
Mrs. Paul L. Schroeder

Mrs. Wadley Glenn
Mrs. Duncan Shepard

Mrs. Fred B. Hodges, Jr.
Mrs. Charles F. Stone, Jr.

Mrs. W. A. Kelley
Mrs. W. C. Waters, Jr.

Mrs. J. H. Lamm
Mrs. George A. Williams

Mrs. Joseph C. Massee
Mrs. Edward S. Wright

Memorial

Mrs. J. K. Fancher, Atlanta, *Chairman*

Mrs. C. C. Aven, Atlanta
Mrs. T. L. Byrd, Atlanta

Timekeepers

Mrs. Jules Victor, Savannah
Mrs. Charles W. Hock, Augusta

Tellers

Mrs. Eugene Ward, Gainesville
Mrs. Louie Griffin, Claxton

Mrs. L. G. Cacchioli, Hartwell
Mrs. Charles K. Singleton, Cairo

Courtesy

Mrs. Robert Crichton, Augusta
Mrs. Neal F. Yeomans, Waycross

Resolutions

Mrs. A. M. Phillips, Macon
Mrs. Ed Roe Stamps, Macon

Reading

Mrs. Chris McLoughlin,
Atlanta
Mrs. Robert H. Vaughan,
Columbus

Mrs. Carl Pittman,
Tifton
Mrs. J. Hubert Milford,
Hartwell

Awards

Achievement

Mrs. D. L. Burns, Valdosta, *Chairman*

Mrs. Virgil B. Williams, Griffin
Mrs. Lee Howard, Savannah

Brawner Trophy

Mrs. Shelley C. Davis, Atlanta, *Chairman*

Mrs. Leo Smith, Waycross
Mrs. Ralph Fowler, Marietta

Doctors' Day

Mrs. Harold M. Smith, Savannah, *Chairman*

Mrs. J. R. S. Mays, Macon
Mrs. Stewart Flanagan, Augusta

Mrs. J. Bonar White Scrapbook

Mrs. Luther Wolff, Columbus, *Chairman*

Mrs. T. A. Sappington,
Thomaston
Mrs. Ted Leigh, Atlanta

Marie S. Burns Safety Award

Mrs. R. J. Mincey, Jr., Thomaston, *Chairman*

Mrs. W. G. Elliott, Cuthbert
Mrs. J. Lon King, Macon

Program of the 31st Convention of the Woman's Auxiliary to the Medical Association of Georgia

Headquarters—*Atlanta Biltmore Hotel*
Registration—*Crystal Lounge, Atlanta Biltmore Hotel*
General Meeting and Exhibits—*Academy of Medicine*

Sunday, May 13

12:00 REGISTRATION

to

5:00 *Crystal Lounge, Atlanta Biltmore Hotel*

1:00 PRE-CONVENTION EXECUTIVE BOARD MEETING DUTCH LUNCHEON

Room 10, Atlanta Biltmore Hotel

PRESIDING

Mrs. Robert C. Major, Augusta, President

5:00 JOINT MEETING MEDICAL ASSOCIATION HOUSE OF DELEGATES AND WOMAN'S AUXILIARY

*Academy of Medicine, 875 W. Peachtree St.,
N. E.*

PRESIDING

Dr. H. Dawson Allen, Jr., Milledgeville, Pres-
ident, Medical Association of Georgia

ORDER OF BUSINESS (See *MAG Delegates
Handbook*)

AUXILIARY PRESIDENT'S REPORT

Mrs. Robert C. Major, Augusta

MILITARY PROBLEMS AND THE CIVILIAN PHYSI- CIAN

Major General Silas B. Hays, Washington,
D. C., Surgeon General, Department of the
Army

Monday, May 14

9:00 REGISTRATION

to

5:00 *Crystal Lounge, Atlanta Biltmore Hotel*

10:00 GENERAL MEETING

*Academy of Medicine, 875 W. Peachtree St.,
N. E.*

CALL TO ORDER

Mrs. Robert C. Major, Augusta, President

INVOCATION

The Rev. Claud M. Haynes, Pastor, Peachtree
Road Methodist Church, Atlanta

PLEDGE OF LOYALTY

Mrs. Olin Cofer, Atlanta

WELCOME

Mrs. A. H. Letton, President, Woman's Aux-
iliary to the Fulton County Medical Society

RESPONSE

Mrs. Nathan DeVaughn, Augusta

INTRODUCTION OF HONOR GUESTS AND PAST PRESIDENTS

Mrs. James N. Brawner, Sr., Atlanta

PRESENTATION OF CONVENTION PLANS AND CHAIRMEN

Mrs. Evert A. Bancker, Atlanta, General
Chairman

INTRODUCTION OF PAGES FOR THE DAY

Mrs. Olin Cofer, Atlanta, Chairman

REPORT OF ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY TO THE MEDICAL ASSO- CIATION OF GEORGIA

Dr. Shelley C. Davis, Atlanta, Chairman

GREETINGS

Dr. H. Dawson Allen, Jr., Milledgeville, Pres-
ident, Medical Association of Georgia

INTRODUCTION OF GUEST SPEAKER

Mrs. Shelley C. Davis, Atlanta

ADDRESS

Mrs. Richard F. Stover, Miami, Fla., Chairman,
Mental Health Committee, Auxiliary to
AMA

BUSINESS SESSION

CONVENTION RULES OF ORDER

Mrs. Ralph H. Chaney, Augusta, Parliamen-
tarian

ROLL CALL

MINUTES

Mrs. Joe Arrendale, Cornelia, Recording Sec-
retary

REPORTS

PRESIDENT

Mrs. Robert C. Major, Augusta

PRESIDENT-ELECT (*Presentation of new aux- iliaries*)

Mrs. Walker L. Curtis, College Park

TREASURER (*Including report of auditor*)

Mrs. W. Loyd Osteen, Savannah

ADDENDUM REPORTS

COMPLETE REPORTS (*See 1955-56 Annual Re- port*)

NEW BUSINESS

RECOMMENDATIONS OF EXECUTIVE BOARD

REVISIONS

Mrs. W. Bruce Schaefer, Toccoa, Chairman

REPORT OF CREDENTIALS COMMITTEE

Mrs. Allen H. Bunce, Atlanta, Chairman

MEMORIAL SERVICE

Mrs. J. K. Fancher, Atlanta, Chairman

ANNOUNCEMENTS

ADJOURNMENT

1:00 DUTCH LUNCHEON FOR PAST PRESIDENTS

Piedmont Driving Club, 1215 Piedmont Avenue, N. E.

PRESIDING

Mrs. Shelley C. Davis, Atlanta, Immediate Past President

3:00 CONDUCTED TOUR of the new Atlanta Art Association Galleries, followed by

5:00 TEA sponsored by the Woman's Auxiliary to the Fulton County Medical Society (for Auxiliary Convention Members)

Atlanta Art Association Building, 1262 Peachtree Street, N. E. (transportation provided from rear of Atlanta Biltmore Hotel)

RECEIVING

Mrs. A. H. Letton, Atlanta, President, Fulton County Auxiliary

Mrs. Robert C. Major, Augusta, President, MAG Auxiliary

Mrs. Richard F. Stover, Miami, Fla., Chairman, Mental Health Committee, AMA Auxiliary

Mrs. John J. O'Connell, St. Louis, Mo., President, SMA Auxiliary

Mrs. Walker L. Curtis, College Park, President-elect, MAG Auxiliary

Mrs. H. Dawson Allen, Jr., Milledgeville

Mrs. Evert A. Bancker, Atlanta, General Chairman for Convention

Mrs. McClaren Johnson, Atlanta, General Co-Chairman for Convention

Monday Night, May 14

7:30 GP DAY GENERAL SESSION

(Joint Meeting with MAG)

Ballroom, Atlanta Biltmore Hotel

PRESIDING

Dr. Maurice F. Arnold, Hawkinsville, President-elect, Georgia Academy of General Practice

7:30 PANEL: THEOLOGY AND MEDICINE

MODERATOR

Mr. Ralph McGill, Atlanta, Editor, *The Atlanta Constitution*

PANELISTS

Rev. Das Kelley Barnett, Austin, Texas

Mr. Raymond Cropper, Macon

Dr. Robert Robins, Camden, Ark.

Rev. Roy O. McClain, Atlanta

8:30 THE PHYSICIAN IN COURT

Dr. George F. Lull, Chicago, Secretary and General Manager, American Medical Association

8:40 THE PHYSICIAN AS A MEDICAL WITNESS

Mr. C. Joseph Stetler, Chicago, Director, AMA Law Department

9:00 DEMONSTRATION OF EXPERT MEDICAL TESTIMONY

PARTICIPANTS

Dr. Ralph E. DeForest, Chicago

Mr. Edwin Holman, Chicago

Mr. R. G. Van Buskirk, Chicago

QUESTION AND ANSWER PERIOD (*Audience Participation*)

Tuesday, May 15

9:00 REGISTRATION

to

12:00 *Crystal Lounge, Atlanta Biltmore Hotel*

10:00 GENERAL MEETING

Academy of Medicine, 875 W. Peachtree St., N. E.

CALL TO ORDER

Mrs. Robert C. Major, Augusta, President

INVOCATION

Mrs. Ralph Fowler, Marietta

PLEDGE OF LOYALTY

Mrs. Lehman W. Williams, Savannah

INTRODUCTION OF PAGES FOR THE DAY

Mrs. J. K. Fancher, Atlanta

ANNOUNCEMENT—CONVENTION PLANS

Mrs. McLaren Johnson, Atlanta, Convention General Co-Chairman

INTRODUCTION OF GUEST SPEAKER

Mrs. Leo Smith, Waycross, Councilor from Georgia to SMA Auxiliary

ADDRESS

Mrs. John J. O'Connell, St. Louis, Mo., President, Woman's Auxiliary to the Southern Medical Association

THE MEDICAL ASSOCIATION OF GEORGIA AND ITS AUXILIARY IN 1956-57

Dr. Hal M. Davison, Atlanta, President-elect, MAG

BUSINESS SESSION

ROLL CALL AND MINUTES

Mrs. Joe Arrendale, Cornelia, Recording Secretary

REPORT OF BY-LAWS AND PROCEDURES COMMITTEE

Mrs. W. Bruce Schaefer, Toccoa, Chairman

REPORT OF BUDGET AND FINANCE COMMITTEE

Mrs. Leo Smith, Waycross, Chairman

REPORT OF RESOLUTIONS COMMITTEE

Mrs. A. M. Phillips, Macon, Chairman

REPORT OF CREDENTIALS COMMITTEE

Mrs. Allen H. Bunce, Atlanta, Chairman

REPORT OF COURTESY COMMITTEE

Mrs. Robert Crichton, Augusta, Chairman

REPORT OF AWARDS COMMITTEES

ACHIEVEMENT—Mrs. D. L. Burns, Valdosta, Chairman

DOCTORS' DAY—Mrs. Harold M. Smith, Savannah, Chairman

MRS. J. BONAR WHITE SCRAPBOOK—Mrs. Luther H. Wolff, Columbus, Chairman

BRAWNER TROPHY FOR GENERAL EXCELLENCE—Mrs. Shelley C. Davis, Atlanta, Chairman

MARIE S. BURNS SAFETY AWARD—Mrs. R. J. Mincey, Jr., Thomaston, Chairman

REPORT OF NOMINATING COMMITTEE

Mrs. Edgar M. Dunstan, Decatur, Chairman

ELECTION OF OFFICERS

INSTALLATION OF OFFICERS

Mrs. Eustace A. Allen, Atlanta, Past President,

Woman's Auxiliary to the AMA, Past President, Woman's Auxiliary to MAG

PRESENTATION OF PRESIDENT'S PIN

Mrs. Robert C. Major, Augusta, Retiring President

INAUGURAL ADDRESS—ANNOUNCEMENT OF 1956-57 CHAIRMEN

Mrs. Walker L. Curtis, College Park, President

PRESENTATION OF PAST PRESIDENT'S PIN

Mrs. Joseph Yampolsky, Atlanta

ANNOUNCEMENTS

ADJOURNMENT

1:00 LUNCHEON-FASHION SHOW (For Auxiliary Convention Members)

Progressive Club, 1050 Techwood Dr., N. W. (transportation provided from rear of Atlanta Biltmore Hotel)

PRESIDING

Mrs. Robert C. Major, Augusta

Tuesday Night, May 15

6:30 SOCIAL HOUR—Sponsored by the Fulton County Medical Society

Piedmont Driving Club, 1215 Piedmont Ave., N. E.

8:00 PRESIDENT'S BANQUET, MEDICAL ASSOCIATION OF GEORGIA

Piedmont Driving Club, 1215 Piedmont Ave., N. E.

Wednesday, May 16

9:00 POST - CONVENTION EXECUTIVE BOARD DUTCH BREAKFAST (1956-57 Officers, Chairmen, District Managers, County Presidents, State Past-Presidents and Councilor to SMA Auxiliary)

Room 10, Atlanta Biltmore Hotel

PRESIDING

Mrs. Walker L. Curtis, College Park, President

9:30 JOINT GENERAL BUSINESS SESSION (All MAG and Auxiliary Members and Guests)

Exhibit Hall Meeting Room, Atlanta Biltmore Hotel

**Pledge of Loyalty
to the**

**Woman's Auxiliary
to the**

Medical Association of Georgia

I pledge my loyalty and devotion to the Woman's Auxiliary to the Medical Association of Georgia. I will support its activities, protect its reputation, and ever sustain its high ideals.

Collect

"Keep us, O God, from pettiness; let us be large in thought, word and deed.

Let us be done with fault-finding and leave off selfseeking.

May we put away all pretense, and meet each other face to face without self-pity and without prejudice.

May we never be hasty in judgment, and always generous.

Let us take time for all things; make us to grow calm, serene, gentle.

Teach us to put into action our better impulses, straightforward and unafraid.

Grant that we may realize it is the little things that create differences; that in the big things of life we are one.

And may we strive to reach and to know the great common woman's heart of us all, and, O, Lord God, let us not forget to be kind."

Rules to Govern the Convention

1. The voting body of the convention shall consist of the members of the Executive Board of the Woman's Auxiliary to the Medical Association of Georgia and the duly accredited delegates from the county auxiliaries. No one is entitled to vote until registered.
2. To gain recognition, a delegate is requested to rise, address the chair, give her name and the name of her auxiliary.
3. No delegate shall speak more than twice on the same subject, and is limited to two minutes each time.
4. Badges must be worn by members of the voting body during all general sessions of the convention.
5. Delegates' privileges are not transferable.
6. All motions shall be presented in writing to the Recording Secretary. They shall be signed by the persons making and seconding the motion.
7. All original motions on resolutions shall be made by submitting two copies, one to the Resolutions Committee and one to the Recording Secretary.
8. All persons appearing on the program must be seated near the platform when the session opens.

Whispering conversations greatly retard the business of the meeting. Order must be maintained at all times. Please be prompt. Meetings will begin promptly at the time announced.

abstracts by georgia authors



Langmuir, Alexander D., Neal Nathanson, and William Jackson Hall, C. D. C., Public Health Service, U. S. Dept. of Health, Education and Welfare, Atlanta, Ga. "Surveillance of Poliomyelitis in the U. S. in 1955," *AM. J. PUB. HEALTH.* 46:75-88 (Jan) 1956.

The National Poliomyelitis Surveillance Program was initiated in April 1955 to serve as a clearing house for the collection, consolidation, and dissemination of all pertinent epidemiologic information concerning the poliomyelitis problems facing the nation. Headquarters of the program are located in the Communicable Disease Center in Atlanta, Georgia. All states and territories are collaborating in the program. More than 40 laboratories are participating. Epidemic Intelligence Service Officers have served with first priority duty throughout the spring and summer and many are still working essentially full time on poliomyelitis.

The Surveillance Program has been concerned with two main problems, 1) the epidemiologic evaluation of the safety, and 2) the measurement of the effectiveness of the vaccine.

A total of 204 cases of poliomyelitis with 11 deaths are known to have occurred in association with vaccine manufactured by Cutter Laboratories. Of these, 79 were among vaccinated children, 105 among family contacts of vaccinated children and 20 among community contacts. The epidemiologic pattern of these cases, including 1) their geographic distribution, 2) the association of cases with particular lots of vaccine, 3) the grouping of the onsets of most of the cases with appropriate incubation periods following inoculation, and 4) the correlation between the site of inoculation and the site of first paralysis in a majority of the vaccinated cases, supports the conclusion that live virus in infective amounts was present in some distribution lots of Cutter vaccine.

A problem was also encountered in the epidemiologic evaluation of a few cases of poliomyelitis that occurred in association with one lot of vaccine manufactured by Wyeth Laboratories. Except for the difficulties with some lots of Cutter and one lot of Wyeth vaccine, however, no other situation involving the possibility of unsafe lots of vaccine was recognized in the more than four million inoculations that were given in April and early May.

Since the middle of May, when a complete revision of safety standards and clearance procedures was adopted, no epidemiologic evidence has come to light that tends to render suspect any lot of vaccine of any manufacturer.

Preliminary reports indicate encouraging results regarding the effectiveness of the vaccine. The restriction of inoculations to 1st and 2nd grade school children during the spring and summer of 1955 provided a unique opportunity for special studies to evaluate effectiveness. Approximately 20 states are conducting such investigations. Tentative results, subject to modification and revision, reveal that the attack rates for paralytic polio are from two

to more than five times greater in the unvaccinated than in the vaccinated children. Less marked but favorable differences are reported for non-paralytic cases.

Confirmation of these preliminary findings has been obtained from a study of the pattern of the age distribution of cases of poliomyelitis reported this year from 33 states. A sharp reduction in paralytic attack rates in seven and eight-year-old children has been observed, in comparison to the expected rates based on past experience. This finding constitutes an independent confirmation of the effectiveness of the vaccine as used this year.

Rinker, J. Robert, Dept. of Urology, Medical College of Ga., Augusta, Ga. "Use of a Lock Splint in Intubated Ureterotomy," *J. UROL.* 75:52-54 (Jan) 1956.

The splint is used in surgery of the lower ureter and provides drainage of the renal pelvis obviating the need for a second surgical procedure, nephrostomy or pyelostomy. The No. 10F. splinting catheter is placed in the ureter through the incision. The locking splint is then passed through the wall of the ureter, through a drilled hole in the side of the splinting catheter and up its lumen to the renal pelvis. The No. 10F. ureteral splinting catheter will accommodate a No. 7F. polyethylene locking catheter in its lumen. On removing the splint the locking catheter is removed first; this frees the splinting catheter so it can be removed from the bladder with the cystoscope. Newer plastic materials make a large lumen and thin-walled catheter possible. Polyvinyl is ideal from the standpoint of flexibility but inferior to polyethylene in preventing chemical reaction of the urine and deposition of crystals on the splints. (3 illustrations)

Rice, W. G., and May Yamaoka, Medical College of Georgia, Augusta, Ga. "Clinical Applications of Zone Electrophoresis of Serum Proteins," *SOUTH. M. J.* 49:24-32 (Jan) 1956.

Zone electrophoresis of human serum using filter paper strips provides a practical means of studying serum proteins quantitatively. Accurate quantitation using involved apparatus is unnecessary and of doubtful practical clinical value since significant alterations are readily seen in the dyed strips with the unaided eye. Electrophoresis is particularly valuable in the differentiation of the various hypoproteinemias and agammaglobulinemias and in the diagnosis of multiple myeloma. Quantitatively abnormal globulin fractions may be apparent by this method even through the A/G ratio is normal. The protein changes in lipid nephrosis, in hypersensitivity diseases, in hepatic disease and in active tuberculosis are illustrated. An unusual protein pattern seen in pemphigus in which all protein fractions were low excepting an elevated alpha globulin was shown. Further data on this type of case in which there may be selective losses of protein components is needed.

Abbott, Osler A., Emory University Hospital, Emory University, Ga. "Present Concepts Relative to Autonomic Nerve Surgery in the Treatment of Pulmonary Disease," *AM. J. SURG.* 90:479-489 (Sept.) 1955.

This article is part of a symposium on Thoracic Surgery presented by the above journal throughout the year 1955. It discusses the historical background of attacks upon both the sympathetic and parasympathetic nervous system relative to pulmonary disease. A detailed discussion of the physiological considerations and the present status of knowledge relative to function of the pulmonary autonomic nervous system, both in the animal and the human, is presented. Details of basic work along this line, done in the author's laboratory, are also included. This is followed by a discussion of clinical experiences with pulmonary denervation and the author's present opinions relative to the possible value of autonomic denervation in various diseases. With bronchial asthma their experiences have been that in patients who have proven to be adrenalin resistant, post-ganglionic dorsal sympathectomy can be of value. In patients in whom the history demonstrates the origin of the disease in association with an episode of pulmonary destruction, excision of a localized area of destroyed lung tissue, plus pulmonary vagotomy has led to long-term cures of the disease.

In inoperable bronchogenic carcinoma, pulmonary vagotomy is useful for the control of intractable cough. In patients with bronchiectasis and severe bronchospasm, or allergy, and in patients with bronchorrhea autonomic nerve surgery has not proven useful. The author then goes into detail with the present approach to pulmonary emphysema, utilizing excision of destroyed areas of lung tissue along with total vagotomy. The present theory of the etiology of pulmonary emphysema was produced by a study of 684 patients. The importance of detailed objective physiological studies in association with any pulmonary autonomic surgery is stressed and outlined.

Greenblatt, Robert B., Medical College of Georgia, Augusta, Ga. "Sex Reversal in Pseudohermaphroditism," *AM. J. OBST. & GYNEC.* 70:1165-1180 (Dec.) 1955.

A group of patients were selected from the 25 pseudohermaphrodites studied at the Medical College of Georgia in order to illustrate certain points in diagnosis and management, as well as in mismanagement.

The psychic make-up of the individual, rather than the gonadal sex, should be the decisive factor in determining the direction in which the transformation should be made.

At birth, infants who present evidence of imperfect sex differentiation should not be immediately labeled with a definite Christian name until studies are performed to clarify the sexual status. The appearance of the external genitals should not be the criterion upon which to base a diagnosis of "male" or "female" in these cases.

Sex reversal and development along

more normal lines are possible through the feminizing effect of cortisone in congenital adrenal hyperplasia, and through operation in the excessively virilized females. In the male pseudohermaphrodites, surgery to reconstitute the male should be reserved for the really few masculinized patients. Otherwise, castration and excision of the clitoris, when indicated, with formation of a vaginal canal by minor surgical procedures, appear to be the method of choice. Inter-mittent but persistent estrogen therapy is advisable to enhance vulvovaginal maturation, breast development, and body contour. The social rehabilitation and psychological adjustment, as a rule, prove gratifying. Effeminate pseudohermaphrodites never quite make the grade as adequate males, in spite of androgens and the best that surgery has to offer.

Ellison, Robert G., Walter J. Brown, Jr., Elmer E. Hague, Jr., and William F. Hamilton, Medical College of Georgia, Augusta, Georgia. "Physiologic Observations in Experimental Pulmonary Insufficiency," *J. THORACIC SURG.* 30:633-641 (Dec) 1955.

Total pulmonary valvectomy was performed on 16 dogs during inflow venous stasis. While hypothermia was used at first, a lower mortality rate was achieved using normothermic conditions and inflow stasis limited to two minutes. Ten long term survivors were observed up to 14 months. None of the dogs presented deleterious effects of pulmonary insufficiency. All had both systolic and diastolic murmurs. An average right ventricular-pulmonary artery systolic pressure gradient of 15 millimeters of mercury was observed. The amount of blood ejected during systole was abnormally large because it included both regurgitative blood as well as that coming through the tricuspid valve. The acceleration of the column of blood in the pulmonary artery to an unusually high velocity with creation of turbulence was postulated as a possible cause of the RV-PA pressure gradient. Pulmonary artery diastolic pressures were uniformly low. Right ventricular end-diastolic pressures were normal. Cardiac enlargement occurred in only two dogs. Electrocardiograms were normal in all cases.

It was felt that this study supported the clinical impression that some degree of pulmonary insufficiency is tolerated in the course of pulmonary valvulotomy. In the presence of associated ventricular septal defect, however, pulmonary insufficiency might lead to right ventricular failure.

Alden, Herbert S., Dept. of Clinical Medicine, Emory University, Ga. "Industrial Dermatitis," *ANN. ALLERGY* 13:695-699 (Nov-Dec) 1955.

This paper attempts to point out that, with an increasing industrialization of the South, and particularly of Georgia, it is necessary for physicians to understand clearly the nature and the differences between "industrial accident" and "occupational disease." The author states that it is essential that there must be better communication between the specialty groups practicing medicine, the executives of industry, the laboring man, the industrial physician, and the general public; in order that patients suffering from industrial injury may understand their condition, and get their just dues.

Each of those involved in industrial dermatitis—the patient, the physician first

seeing the patient, the employer, and the family of the employee, must clearly understand what their responsibilities and their dues are in such conditions, and it is the duty of the examining physician to inform them of these facts. The author presents an outline of the criteria and facts which must be considered in the diagnosis and final substantiation of eruptions of the skin.

The author, in the concluding paragraphs writes, "—The facts must be known to the physician, to the employer, to the employee, and to the insurance carriers, in order that the conditions confronting them all can be equitably settled. It is not enough, therefore, for physicians to decide merely upon cause and effect. They must, in addition, be prepared to relieve, change, and remove those causes and effects."

McGeachy, T. English, William Bloomer, and Arthur J. Merrill, Emory University Medical School, Emory University, Ga. "Post-nephrectomy Renal Failure in a Patient with a Normal Preoperative Blood Non-Protein Nitrogen," *AM. J. MED.* 20:157-158 (Jan) 1956.

Often the blood NPN or urea is the only study made of renal function before a damaged kidney is removed. In most instances the patient with a normal blood urea seems to do well.

We reported the case of a 77 year old woman with preoperative normal NPN. Following unilateral nephrectomy for chronic pyelonephritis she went into coma due to loss of sodium chloride and potassium. She responded rapidly to administration of these electrolytes.

Blood NPN determination alone may not be adequate to estimate renal function prior to nephrectomy. Tubular insufficiency with electrolyte depletion which could have resulted fatally became evident during the postoperative period.

Witham, A. Calhoun, and H. B. Jones, Medical College of Georgia, Augusta, Ga. "The Relative Value of Electrocardiography and Photocentgenography for Cardiac Surveys," *AM. HEART J.* 51:186-198 (Feb) 1956.

The mass survey photocentgenogram and a four lead electrocardiogram was applied to 126 cases of known heart disease and 92 people without cardiovascular involvement. In the interpretation of borderline x-rays, mensuration was thought to be superior to inspection because of its objectivity. The cardiothoracic ratio when the internal diameter of the chest was measured at the level of the fourth anterior intercostal space seemed as good as the widely accepted tables for prediction of transverse diameter with the added advantage that it was unnecessary to know height and weight of patient. Contour interpretation, in the absence of definite cardiac enlargement, disproportionately increased the number of false positive readings. Various methods and combinations thereof were tested. In the interpretation of x-rays and ECG's, there was demonstrated a direct relationship between the efficiency of case detection and the number of false positives. The four lead electrocardiogram described herein detected a satisfactory number of cardiacs, but had a false positive rate of 11 per cent. When minor electrocardiographic abnormalities were ignored, there was a sharp fall both in the detection rate and in false positives. If the cardiothoracic ratio were combined

with four lead ECG, interpretation of the misleading left cardiac border with normal transverse diameter might be circumvented. Detection rate was greater than either method alone (87 per cent) and false positives were at a relatively modest figure (16 per cent). The electrocardiographic method was superior to photocentgenography alone. Statistical authority for these statements is presented.

Tappen, N. C., Dept. of Anatomy, Emory University, Ga. "Relative Weights of Some Functionally Important Muscles of the Thigh, Hip, and Leg in a Gibbon and in Man," *AM. J. PHYS. ANTHROPOL.* 13:415-420 (Sept) 1955.

Muscles of the lower extremity of an adult gibbon were weighed. Quadriceps are four times as heavy as hamstrings, a more extreme deviation from quadrupeds than man. In this respect gibbon locomotion appears preadaptive to the human type of locomotion. Soleus is nearly as heavy as Gastrocnemius, once more tending toward the human situation. Gluteal muscles retain the pattern of quadrupeds, showing no trend toward fully erect posture.

Kite, J. Hiram, 490 Peachtree St., N.E., Atlanta, Ga. "Flat Feet and Lateral Rotation of Legs in Young Children," *J. INTERNAT. COLL. SURGEONS*, 25:77-84 (Jan) 1956.

Many articles have been written on the treatment of flatfeet. Little has been written about the prevention of flatfeet. Present day medicine is as much interested in the prevention of disease and disabilities as it is in the cure. If we are to prevent flatfeet we must know the cause.

It is the opinion of the author that most cases of flatfeet and lateral rotation of the legs in small children is caused by the child's sleeping constantly on the abdomen in the frog position, during the first four months before the child can turn over.

To prevent this the child should sleep in various positions, preferably on his side. When the deformity is present, the lateral rotation is treated by rolling the legs medially. The flatfoot deformity is corrected by stretching the forefoot down and in to restore the longitudinal arch to the foot. This is supplemented by swung-in shoes.

McClure, James H., and William L. Caton, 69 Butler St., S.E., Atlanta, Ga. "Rectal Temperatures of Term Newborn Infants with Apnea," *J. PEDIAT.* 48:23-27 (Jan) 1956.

A study of the temperatures of newborn term infants led to the chance observation that apnea neonatorum may be accompanied by profound alterations in the rectal temperature.

Examination of continuous rectal temperature records of four term infants with apnea found that apnea of the newborn infant may be "accompanied" by a rapid rise in the rectal temperature (as great as 2.5 degrees F./minute). The first respirations following apnea occur with a precipitous fall (as great as 1.3 degrees F./30 secs.).

This is the first time that data depicting a change in body temperature with apnea has been described in the literature.

The authors speculate on the possible changes in the oxygen dissociation curve, absorption coefficient of oxygen, and blood PH. (Four figures.)

Council of the MAG

February 5, 1956

J. W. Chambers, LaGrange, Chairman of Council, called the meeting held via a conference phone call, to order at 1:15 p.m., February 5, 1956.

The following members were in on the call: H. Dawson Allen, Milledgeville; Hal M. Davison, Atlanta; William Harbin, Rome; David Henry Poer, Atlanta; George R. Dillinger, Thomasville; W. G. Elliott, Cuthbert; J. W. Chambers, LaGrange; Mark S. Dougherty, Atlanta; Henry H. Tift, Macon; D. Lloyd Wood, Dalton; Neal F. Yeomans, Waycross, and W. Bruce Schaefer, Toccoa; R. C. McGahee, Augusta; Stephen W. Brown, Augusta; Thomas Goodwin, Augusta; and the Messrs. Milton D. Krueger and John F. Kiser of the Headquarters Office staff.

Talmadge Memorial Hospital Constitutional Amendment Legislation

Chairman Chambers, after giving a resume and allowing discussion, read the following proposed Constitutional amendment for introduction into the 1956 Georgia General Assembly:

"BE IT RESOLVED BY THE GENERAL ASSEMBLY OF GEORGIA: Section 1. Article VIII, Section 4, of the Constitution is hereby amended by adding a new paragraph, to be known as paragraph 2 to read as follows:

"Paragraph 2. The Board of Regents of the University System of Georgia, or any other agency, which in the future has jurisdiction of the Eugene Talmadge Memorial Hospital, is hereby authorized to allow the medical practitioners who are full-time members of the faculty of the Medical College of Georgia to treat pay patients in such hospital and is further authorized to allow such medical practitioners to charge and accept fees for their services from patients who are financially able to pay for such services. Provided further that said members of the faculty shall not collect more than 20

per cent of the amount of their salaries in any calendar year, nor spend more than 20 per cent of their time in any calendar year engaged in the treatment of such private patients. The above limitations upon the time such medical practitioners may devote to the care of professional pay patients and the limitation upon the amount that they can receive for such services shall be prescribed by the President of the Medical College of Georgia . . ."

Chairman Chambers said that authorities of the Eugene Talmadge Memorial Hospital (the Chancellor of the University System, the President of the Medical College of Georgia, and the Superintendent of the Eugene Talmadge Memorial Hospital) were reportedly in favor of such a resolution's being submitted as a Constitutional amendment at this time.*

The Constitutional amendment was approved by the Council unanimously.

The meeting adjourned at 1:35 p.m.

Addendum

*After this meeting adjourned it was learned on February 6 that the Chancellor of the University System and the President of the Medical College of Georgia were not in favor of any legislation's being introduced in the Georgia General Assembly. This information negated the approval of the Council of February 5 of the Constitutional amendment for introduction in the Georgia General Assembly, as it had been believed by the Council that this was to be a cooperative effort.

It was learned on February 9 that the measures proposed in the Constitutional amendment were not necessary as Mr. Roy Harris informed the MAG orally that it *would not* violate the present Constitution of the State of Georgia for medical practitioners to charge and accept fees for their services rendered on State property. Mr. Harris also said that these measures would be written into the present operational plan of the Board of Regents for the Eugene Talmadge Memorial Hospital which would be ready to be brought before the members of the Medical Association of Georgia by the time of the Annual Session, May 13-16, 1956.

200-Bed Emergency Hospital to be Demonstrated at Annual Session

THE MEDICAL Civil Preparedness Committee of the MAG announces that the new Civil Defense 200-bed Emergency Hospital is now available for distribution to the states in the matching fund program. This ingenious and practical hospital will be the basis for emergency medical care in case of major disasters, since many of the existing hospitals may be destroyed. It can be packed into a 10x10x20 ft. trailer-truck and moved easily anywhere in the state to be set up in a school or other suitable building. Under certain conditions, it can be moved by cargo plane.

This Civil Defense 200-bed Emergency Hospital, as

well as its companion, the Mobile First Aid Station (Collecting-Clearing Unit), will be demonstrated at the 1956 Annual Session of the MAG in the First Baptist Church of Atlanta (Cypress Street entrance), just one block south of the rear of the Exhibit Hall of the Biltmore Hotel, at the following times: (1.) *Monday, May 14, 6:00 to 9:30 P. M.*, the two units will be set up. (2.) *Tuesday, May 15, and Wednesday, May 16, 8:30 A. M. to 5:00 P. M.*, the units will have guides to show you around, and motion picture and other graphic material available. (3.) *Wednesday, May 16, 5:00 to 9:00 P. M.*, the units will be disassembled and repacked.

ANNOUNCEMENTS

Specialty Societies of the State of Georgia

- 1—*Anesthesiologists, Georgia Society of*—May 13-14, Atlanta Biltmore Hotel; October meeting undecided.
- 2—*Chest Physicians, Georgia Chapter, American College of*—May 13-14, Atlanta Biltmore Hotel.
- 3—*Diabetic, Georgia Association*—May 14, Atlanta Biltmore Hotel.
- 4—*General Practice, Georgia Academy of*—October 17-18, General Oglethorpe Hotel, Savannah.
- 5—*Heart, Georgia Association*—September 14-15, General Oglethorpe Hotel, Savannah.
- 6—*Industrial Surgeons, Georgia Association*—May 14, Atlanta Biltmore Hotel.
- 7—*Obstetrical and Gynecological, Georgia State Society*—May 14, Atlanta Biltmore Hotel; October meeting undecided.
- 8—*Orthopedic, Georgia Association*—May 13-14, Atlanta Biltmore Hotel; September 22-23, King and Prince Hotel, St. Simons Island.
- 10—*Pathologists, Georgia Association of*—May 15, Atlanta Biltmore Hotel; November meeting to be decided at May meeting.
- 11—*Pediatric, Georgia Society*—May 13, Atlanta Biltmore Hotel; October 26, Atlanta.
- 12—*Physicians, American College of*—(this is a Southeastern society and there is not a Georgia chapter)
- 13—*Radiological, Georgia Society*—May 13-14, Atlanta Biltmore Hotel; November 19-20, St. Simons Island.
- 14—*Surgeons, Georgia Chapter, American College of*—May 13, Atlanta Athletic Club; September 28-29, King and Prince Hotel, St. Simons Island.
- 15—*Trudeau, Georgia Society*—May 14, Atlanta Biltmore Hotel; September meeting undecided.
- 16—*Urological, Georgia Society*—May 14, Atlanta Biltmore Hotel.

American Congress of Physical Medicine and Rehabilitation Annual Prize Lecture—Prize for an essay on any subject relating to physical medicine and rehabilitation.

Primarily directed to medical students, interns, residents, and graduate students. Manuscripts must be in the office of the ACPMR, 30 North Michigan Ave., Chicago 2, Ill., not later than June 1, 1956. Manuscripts must not exceed 3000 words and the number of words should be stated on title page. Winner receives a cash award of \$200, a gold medal, certificate, and invitation to present the contribution at the 34th Annual Session of the Congress, September 9-14, 1956, at the Ambassador, Atlantic City, N. J. For further information, write to the executive secretary, Dorothea C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Ave., Chicago 2, Ill.

Hawaii Medical Association Centennial Celebration and Scientific Congress—Honolulu, April 22 to 29, 1956. Every physician in the U. S. is invited to celebrate the centennial with the Hawaii Medical Association. There will be a short but worthwhile professional program on Monday and Tuesday mornings, Centennial Celebration Pageant Tuesday night, and a traditional luau (Hawaiian feast) Thursday night, with Polynesian entertainment. Tours are planned for each day of the meeting. For information and reservations write to the Hawaii Medical Association, 510 South Beretania St., Honolulu 13, Hawaii.

American College of Allergists Graduate Instructional Course and 12th Annual Meeting—Hotel New Yorker, New York City, April 15-17, 1956 (Course) and April 18-20, 1956 (Meeting). For further information write to Dr. Fred W. Wittich, Secretary-treasurer, American College of Allergists, Inc., 401 LaSalle Bldg., Minneapolis 2, Minn.

American Cancer Society 3rd National Cancer Conference—Sheraton-Cadillac Hotel, Detroit, Mich., June 4, 5, and 6, 1956. Morning and afternoon sessions will begin with a general session with an outstanding speaker; the general sessions will break into various symposia to discuss cancer of different body sites. Copies of the program and advance registration cards may be obtained from the National Cancer Conference Coordinator, American Cancer Society, 521 West 57th St., New York 19, N. Y.

International Academy of Proctology 8th Annual Convention—Drake Hotel, Chicago, April 23-26, 1956. For details write to Dr. Alfred J. Cantor, Secretary, International Academy of Proctology, 147-41 Sanford Ave., Flushing 55, N. Y.

Conference on Leukemia, sponsored by the Louisiana Division of the American Cancer Society—April 10 and 11, 1956, New Orleans, La. Principal speakers include: W. R. Arrowsmith, M.D., Ochsner Clinic; G. John Buddingh, M.D., L. S. U. School of Medicine; Joseph H. Burchenal, M.D., Sloan Kettering Institute for Cancer Research; Walter J. Burdette, M.D., Univ. of Mo. School of Medicine; Jacob Furth, M.D., Children's Cancer Research Foundation; Alfred Gellhorn, M.D., College of Physicians and Surgeons, Columbia Univ.; Ludwik Gross, M.D., Bronx (N. Y.) VA Hospital; Arthur Kirschbaum, M.D., Baylor Univ. School of Medicine; Lloyd W. Law, M.D., National Cancer Institute; Charles C. Sprague, Tulane Univ. School of Medicine; Jerome T. Syverton, M.D., Univ. of Minn., and Arthur C. Upton, M.D., Oak Ridge National Laboratory. For information, communicate with the American Cancer Society, 822 Perdido St., New Orleans, La., immediately.

American College of Chest Physicians 22nd Annual Meeting—June 6-10, 1956, Hotel Sherman, Chicago, Ill. Formal presentations will be augmented by symposia, round-table luncheon discussions, seminars, and motion pictures. Examinations for fellowship in the College will be held on June 7, 1956. No registration fee. For copies of the program, write to the Executive Offices, American College of Chest Physicians, 112 East Chestnut St., Chicago 11, Ill.

Short Course in Pediatric Advances, for Pediatricians and General Practitioners—May 28-June 1, 1956, The Children's Hospital of Philadelphia. A refresher course conducted by the staff of the hospital in collaboration with the Univ. of Pa. and the Camden Municipal Hospital. Tuition—\$100.00.

Short Course in Practical Pediatric Hematology—June 4-6, 1956, The Children's Hospital of Philadelphia. Conducted by Dr. Irving J. Wolman and other members of the Hematology department of the hospital. Tuition—\$60.00.

Short Course in Blood Group Incompatibilities and Erythroblastosis Fetalis—June 7 and 8, 1956, The Children's Hospital of Philadelphia. Conducted by Dr. Thomas R. Boggs, Jr. Tuition—\$50.00.

For further information, write to Irving J. Wolman, M.D., Children's Hospital of Philadelphia, 1740 Bainbridge St., Philadelphia 46, Pa.

Two-week Course in Regional Anesthesia—May 7-19, 1956, New York Univ. Post-Graduate Medical School. Course intended to be of interest to specialists and others working in the fields of rehabilitation, arthritis and other debilitating diseases.

One-week Course in Anesthesiology: Endotracheal and Related Methods—Beginning May 21, 1956, N. Y. U. Post-Graduate Medical School.

Course in Acute Neurological Problems of General Practice—April 30-May 5, 1956, N. Y. U. Post-Graduate Medical School. Will deal with recent developments in diagnosis and therapeutic neurological problems for the practicing physician.

Course in Culdoscopy—April 30-May 4, 1956, N. Y. U. Post-Graduate Medical School. (Will be given in three two-hour periods.)

Advanced Course in Urology (for specialists)—May 14-25, 1956, N. Y. U. Post-Graduate Medical School.

Symposium on Tuberculosis and other Pulmonary Diseases of Childhood—June 4-8, 1956, N. Y. U. Post-Graduate Medical School.

Symposium on Dermatology and Syphilology—May 14-18, 1956, N. Y. U. Post-Graduate Medical School. A critical survey of recent advances in the field, available to specialists.

Course in Orthopedics in General Practice—June 11-13, 1956, N. Y. Review of orthopedic conditions encountered in general practice including common errors made in the treatment of fractures.

Courses in Cardiology—May 7-25, 1956, N. Y. U. Post-Graduate Medical School. A summary of basic knowledge and recent advances in the diagnosis and treatment of heart disease.

Symposium on Modern Therapeutics in Internal Medicine—June 11-22, 1956, N. Y. U. Post-Graduate Medical School. Offers internist and G. P. a concise review of modern therapy in field of internal medicine.

Review Course in General Medicine—July 9-20, 1956, N. Y. U. Post-Graduate Medical School.

Further information on the above courses and others offered during academic year may be obtained from the Dean, Post-Graduate Medical School, 550 First Avenue, New York, N. Y. The School is a unit of the New York Univ.-Bellevue Medical Center.

International College of Surgeons, Southeastern Division Regional Meeting—April 30 and May 1, 1956, Read House, Chattanooga, Tenn. The program will include the presentation of 17 scientific papers, three panels, dinner and luncheon with speakers, and exhibits. For information, write to Dr. William G. Stephenson, 612 Medical Arts Bldg., Chattanooga, Tenn.

DEATHS

WILLIAM PETER COFFEE, Fitzgerald, 68, died on February 7, 1956, following an illness of several weeks. Dr. Coffee's health had been gradually failing for the past few years and he became seriously ill while visiting his daughter in St. Petersburg.

A native of Dodge County, Dr. Coffee was a graduate of the Emory University School of Medicine. He and his family came to Fitzgerald in 1920, and Dr. Coffee had practiced general medicine there ever since, limiting his practice for the past several years because of ill health.

Graveside services were held at the Woodlawn Cemetery in Eastman on February 9, 1956.

Survivors include his wife, the former Miss Bessie Burch, of Eastman, and a daughter, Miss Elizabeth Coffee, of St. Petersburg, Fla.

JOHN ELMO GARNER, Thomaston, died on January 24, 1956, in an Upson County Hospital. He was 75 years old at the time of his death.

Dr. Garner was a native of Upson County and had practiced in Thomaston since 1929. Prior to that time he had practiced medicine in Florida. Dr. Garner was made a Life member of the Medical Association of Georgia a few years ago.

A graduate of Davidson College, he received his medical degree from the University of Maryland. He was active in civic and church work and was a deacon in the First Baptist Church of Thomaston and a past president of the Thomaston Kiwanis

Club. He had also served as a member of the Thomaston Board of Education.

Dr. Garner is survived by two sons, Mr. Frank B. Garner, San Antonio, Texas, and Mr. John E. Garner, Jr., Milledgeville, and two granddaughters.

Funeral services were held from the First Baptist Church with burial in Glenwood Cemetery.

AUBREY HARPER, Wray, died on February 20, 1956, at the age of 84. Dr. Harper is the father of Sage Harper, of Douglas.

Dr. Harper was born in Carroll County; he was a graduate of the Southern Medical School and had practiced medicine in Irwin, Coffee and Ben Hill Counties for 50 years. He was also Postmaster of Wray for 31 years, a member of the Irwin County School Board for 30 years, and a deacon in the New Hope Church for 50 years.

Funeral services were held on February 22, 1956, at the New Hope Baptist Church with burial in the church cemetery.

Survivors, beside Dr. Harper of Douglas and his children, include his wife, the former Miss Mary Lee Brown; five sisters, and three brothers.

MATTHEW K. JENKINS, Atlanta, died on February 6, 1956, at the age of 86. He had practiced in Atlanta for 55 years and was a Life Member of the Medical Association of Georgia.

A native of Gwinnett County, Dr. Jenkins was a member and deacon emeritus of the Jackson Hill Baptist Church and of the Fulton County Medical Society. He was also a Mason.

Survivors include his wife, the former Miss Emylee Trapnell, of Pulaski, and two daughters, Mrs. Allen Vickery, of Atlanta, and Mrs. B. T. Beasley, of Statesboro.

Funeral services were held on February 7, 1956, at Spring Hill with burial in Oakwood Cemetery, Atlanta.

MALCOM E. NOEL, Atlanta, died on February 15, 1956, at the age of 75.

Dr. Noel was born in Albertville, Alabama, and had lived in Atlanta since 1899. He graduated from the old Atlanta Southern College of Pharmacy in 1902 and operated a drug store before entering the University of Alabama Medical School.

(Deaths)

He began his practice of medicine in Atlanta in 1915.

Dr. Noel was a member of the Kirkwood Methodist Church and the Fulton County Medical Society.

Funeral services were held on Friday, February 17th, at the Kirkwood Methodist Church, burial was in Crest Lawn Cemetery. Survivors include his wife; a daughter, Mrs. S. C. Snellgrove, of Atlanta, and a brother, Dr. William Earl Noel, of Boaz, Ala.

JOHN WESLEY ODEN, St. Petersburg, Fla., died February 20, 1956. He was 69 years of age at the time of his death.

A native of Brentwood, Tenn., Dr. Oden had spent most of his career in psychiatric work in Georgia institutions. He is a former superintendent of Milledgeville State Hospital, and had also served at the old Georgia Tuberculosis Hospital at Alto and at the Georgia Training School in Augusta.

He received his doctorate at the University of the South at Sewanee, Tenn. He was a Life Member of the Medical Association of Georgia and a fellow of the American Psychiatric Association. Dr. Oden's permanent residence was in Blackshear, but he and Mrs. Oden had made their home recently with his daughter, Mrs. Kenmore Burns, Jr., and her husband.

Dr. Oden was a member of the Methodist Church in Blackshear and of the Blackshear Masonic Lodge.

In addition to Mrs. Burns, he is survived by his wife, the former Miss Martha Grady; four brothers, Mr. Thomas E. Oden and Lewis Oden, M.D., Blackshear; Mr. Marion Oden, of Brentwood, and Mr. Robert Oden, of Dade City, Fla.; one sister, Mrs. Charles Howell, Pulaski, Tenn., and a grandson.

ATTICUS SAMUEL SANDERS, Lake Burton, died on February 14, 1956. He was 57 years of age at the time of his death. Dr. Sanders had retired from the active practice of medicine about four years ago because of poor health.

A native of Orchard Hill, Dr. Sanders attended Emory College and was graduated from Emory University School of Medicine. He served in the U. S. Navy in both World Wars, retiring from active service in the Seabees after World War II with the rank of commander.

Dr. Sanders was a member of the Glenn Memorial Methodist Church

and the Fulton County Medical Society.

Survivors include his wife, the former Miss Elizabeth Phillips, of Rome; a son, A. S. Sanders, Jr., Atlanta; a daughter, Mrs. H. W. Richter, Atlanta; his mother, Mrs. Julia Withers Sanders, Atlanta, and a brother, Dr. W. B. Sanders, Chapel Hill, N. C.

RALPH L. TAYLOR, Davisboro, died on January 22, 1956, after a long illness. Dr. Taylor was 68 years old at the time of his death. Funeral services were held on January 24th at the Davisboro Methodist Church; interment was in Davisboro Cemetery. Members of the Washington County Medical Society served as honorary pallbearers.

Dr. Taylor was born in Washington County and had practiced medicine in Davisboro for 47 years. He was a member of the Methodist Church of Davisboro, a Woodman of the World, and a Mason.

Dr. Taylor also served as a member of the Davisboro School Board and was chairman of the Washington County School Board for 20 years.

Survivors include his wife, the former Miss Nell Warthen of Sandersville; two daughters, Mrs. Harold Wilson of Atlanta and Miss Georgia Taylor of Davisboro; two sons, William J. Taylor, M.D., Atlanta, and the Rev. Benton Taylor, Patterson; and one grandchild.

THOMAS L. TIDMORE, Atlanta, died on February 5, 1956, at his home in Atlanta. He was 55 years old.

Dr. Tidmore had been chief of anesthesiology at Piedmont Hospital since 1923, the year he was graduated from Emory University School of Medicine. He was a native of Moundville, Ala.

Dr. Tidmore was a member of the First Methodist Church of Atlanta, the Fulton County Medical Society, American Board of Anesthesiology, American Society of Anesthesiology, Pi Kappa Alpha social fraternity, and Phi Chi medical fraternity.

Survivors include his wife; a daughter, Mrs. August B. Turner, Atlanta; two sons, T. L. Tidmore, Jr., M.D., Memphis, Tenn. and Mr. William C. Tidmore of Atlanta; his father, Mr. James C. Tidmore of Moundville; a sister and a brother.

Funeral services were held at Spring Hill, Atlanta, with burial in Crest Lawn Memorial Park.

SOCIETIES

The BEN HILL-IRWIN MEDICAL SOCIETY met on January 31, 1956, in Fitzgerald to elect officers of the society for the current year. Tom F. Little, Ocilla, was elected president; Francis Ward, Ocilla, secretary-treasurer, and Herman Dismukes, Ocilla, was elected delegate to the 106th Annual Session of the Medical Association of Georgia.

E. H. Rynearson, of the Mayo Clinic, Rochester, Minn., delivered the fourth annual Witman Lecture for the BIBB COUNTY MEDICAL SOCIETY on February 3, 1956, at the Pinebrook Inn, Macon. Approximately 200 physicians of the Middle Georgia area attended the gathering. The topic of Dr. Rynearson's talk was "Medical and Surgical Treatment of Thyroid Disease". Dr. Rynearson is professor of medicine at the Mayo Foundation, and head of the department of endocrinology and metabolism at the Mayo Clinic. The speaker was introduced by J. Lon King, President of the Bibb County Medical Society.

When the GEORGIA MEDICAL SOCIETY met on February 14th the speaker was James J. Waring, a native of Savannah and a member of a family distinguished for its contribution to medicine and surgery. Dr. Waring is Director of the Colorado Foundation for Research in Tuberculosis. The subject of his address was "The Control of Tuberculosis". Dr. Waring is a graduate of Yale University; he attended Johns Hopkins Medical School and received his medical degree from the University of Colorado. He joined the medical faculty in 1926 and became a full professor of medicine in 1926. He was made professor of medicine, emeritus, of the University of Colorado School of Medicine in 1952. He is a past president of the National Tuberculosis Association, the American Clinical and Climatological Association, and the American College of Physicians. He is also a past chairman of the American Board of Internal Medicine.

The FULTON COUNTY MEDICAL SOCIETY met on February 2, 1956, at the Academy of Medicine in Atlanta. William H. Chambers, Atlanta, was the speaker.

STEPHENS COUNTY MEDICAL SOCIETY met on January 28, 1956, at the Stephens County Hospital to

elect officers for the year. S. L. Harp, was elected president; M. D. Pittard, vice-president; and C. L. Ayers, secretary. It has been noted that in the past three years, the number of doctors in Stephens County has increased from eight to 14.

The WILKES COUNTY MEDICAL SOCIETY met recently in Washington and elected the following officers for 1956: Robert G. Stephens, president; R. C. Nash, vice-president; and M. C. Adair, secretary-treasurer. The guest speaker at this meeting was Ted Everett, Augusta, who spoke on "Diagnosis and Treatment of Traumatized Kidney". Guests at the meeting were Frank Gibson and Ed Maxwell, Thomson.

PERSONALS

First District

At the meeting of the Georgia Hospital Service Association, Inc., held in Columbus recently, W. W. AIKEN, Lyons, was elected to the Board of Trustees of the Association.

ELLISON R. COOK, III, Savannah, was the guest speaker at a recent Kiwanis Hour evening meeting of the Vidalia Kiwanis Club. In connection with his address, Dr. Cook showed a movie entitled "Pump Trouble".

Dr. and Mrs. L. H. GRIFFIN, Claxton, the latter a director in the First District Chapter of the Georgia Heart Association, attended the meeting in Atlanta recently to kick off the Georgia Heart Fund Campaign. One of the highlights of the meeting was the dinner at which Mr. James Melton, of the Metropolitan Opera Company, was the guest of honor.

ANNE HOPKINS, Savannah, has been elected president and LAWRENCE LEE, JR., Savannah, has been named president-elect of the Chatham-Savannah Health Council. Physicians elected to serve with these officers on the Board of Trustees were ELLISON R. COOK, III, ALBERT J. KELLEY, and DAN H. WILLOUGHBY. Other physician members of the board, by virtue of the offices they hold, are W. D. LUNDQUIST, WALTER W. OTTO, RUSKIN KING, and T. A. PETERSON. At the meeting at which these officers were elected there was a panel discussion on "Meeting Costs of Medical Care". ALBERT J. KELLEY was moderator.

HOWARD J. MORRISON, Savannah, outlined the history of poliomyelitis and the fight against the disease in a recent speech before the Savannah Rotary Club. Dr. Morrison outlined the steps in the development of research that eventually led to the discovery of the Salk vaccine and advocated that children between the ages of one and 15 should be given the vaccine to reduce the chances of each child's contracting paralytic poliomyelitis.

THOMAS P. WARING, Savannah, has been elected vice-president of the Hospital Service Association of Savannah.

Second District

T. J. ARLINE, retired physician of Cairo and Grady County, was 90 years old on January 24, 1956. Dr. Arline practiced medicine for about 60 years before retiring. He is a Life Member of the MAG.

T. GRAY FOUNTAIN, Albany, attended the 10th Annual Meeting of the Georgia Chapter of the American Cancer Society in Macon in February. Dr. Fountain was elected to serve on the Board of Directors at this meeting.

TURNER W. RENTZ, Colquitt, has been elected to serve on the Board of Directors of Physicians' Service, Inc. Physicians' Service is the non-profit Blue Shield plan, with headquarters in Columbus. Dr. Rentz is a native of Baker County and a graduate of the Medical College of Georgia. He interned at Greenville General Hospital and is a member of the Southwest Georgia Medical Society.

ERNEST F. WAHL, Thomasville, spoke at a recent meeting of the Cairo Rotary Club. Dr. Wahl, president-elect of the Georgia Heart Association, explained that cardiac operations are becoming more frequent as medical science discovers ways to return heart patients, through such operations, to a more normal routine of life. Four Cairo physicians were guests at the meeting: C. K. SINGLETON, CARL L. SMITH, J. B. WARNELL, and A. B. REYNOLDS.

Third District

YANCEY F. CARTER, JR., formerly of Ashburn, has become a partner in the Askew Memorial Hospital in Nashville. He will be associated with W. W. TURNER, Nashville. Dr. Carter came to Ashburn in July 1954. A native of Berrien County, he is a graduate of the Medical College of Georgia.

J. T. CHRISTMAS and R. S. ROBINSON, Vienna, have begun keeping office hours in Unadilla four afternoons a week. They will continue to keep their offices open in Vienna as usual.

W. G. ELLIOTT, Cuthbert, vice-chairman of the Cuthbert Unit of the American Cancer Society, attended the recent state-wide conference on cancer held at the Dempsey Hotel in Macon.

RICHARD M. HASKINS, JR., Columbus, has been named Columbus' "Negro Man of the Year". He was presented a trophy by the Young Men's Progressive Club at a ceremony at the Friendship Baptist Church. Dr. Haskins is a native of Texas. He has been active in the Negro Boys Club, March of Dimes, Boy Scouts, Tuberculosis Association, YMCA, Columbus Coaches and Officials Association, and other civic projects.

WALTER D. MARTIN, Dawson, has been appointed chairman for Terrell County of the 1956 Easter Seal Appeal to aid Georgia's Crippled Children. The Easter Seal Appeal is sponsored by the Georgia Society for Crippled Children and Adults as part of a nationwide campaign conducted simultaneously in the 48 states and possessions.

J. C. PATTERSON, Cuthbert, has been elected to serve on the Board of Trustees of the Georgia Hospital Service Association (Blue Cross Plan) representing the Patterson Hospital in Cuthbert.

JOHN H. ROBINSON, III, Americus, attended the recent annual meeting of the Physicians' Service, Inc. Dr. Robinson is a member of the Board of Directors.

E. FAXTON SEAY, Marshallville and Ft. Valley, has been elected chief of the medical staff of the Peach County Hospital. FRANK VINSON, Ft. Valley, is vice chief-of-staff, and DANIEL E. NATHAN, Ft. Valley, is secretary. Dr. Seay succeeds A. SMOAK MARSHALL, Ft. Valley, who was elected by the Peach County Hospital Authority to serve on the executive committee of the hospital.

LUTHER H. WOLFF, Columbus, was reelected president of Physicians' Service, Inc., at the annual meeting of the board of directors in January. Physicians' Service, Inc., is

the Blue Shield Plan which serves most of the State of Georgia. Officers to serve with Dr. Wolff are JOHN T. MITCHELL, LaGrange, vice-president; GEORGE G. SCHUESSLER, Columbus, re-elected secretary; and Mr. J. Mark Mote, Columbus, re-elected treasurer. Elected to the executive committee were Dr. Wolff, Dr. Schuessler, and GEORGE L. EPPS, Columbus.

Fourth District

ROBERT MONROE LOVVORN, Bowdon, celebrated his 90th birthday on February 3, 1956. Dr. Lovvorn was born at Newell, Ala., in 1866 and moved with his family to Bowdon in December 1877. He was graduated summa cum laude from the Medical College of Georgia in 1889. He began practicing in Wedowee, Ala. In 1890 he entered New York University to do post-graduate work. He returned to Bowdon to resume the private practice of medicine. He was married in 1893 to Miss Dana Merrill. Dr. Lovvorn joined the Masonic Order in 1892 and has since held every office in the organization. In 1904 he was ordained as a minister of the Baptist Church and served churches in Georgia and Alabama. Dr. Lovvorn for many years served as Chairman of the Board of Trustees of Bowdon College, as director of the Bowdon Railroad, and director and treasurer of the Bowdon Construction Company. He has been mayor of the town twice, in fact there is nothing in the town of Bowdon that has not been affected by his civic enterprise.

T. M. MARTIN, JR., Bowdon, and T. E. REEVE, Carrollton, have been appointed chairmen of the Finance and Professional Education Committee of the Carroll County unit of the American Cancer Society. The two physicians will not only play leading roles in the year-round educational fight against cancer but will spark the annual Cancer Society fund drive during April.

C. B. PALMER, Covington, took part in a recent television program over an Atlanta station which had as its subject "Overweight". Dr. Palmer participated in a panel discussion with M. V. MURPHY, DAVID HENRY POER, SCOTT W. TARPLEE, Atlanta, and GEORGE L. WALKER, Griffin. The program is put on by the Public Relations Committee of the Fulton County Medical Society.

JAMES W. PURCELL, JR., Covington, has been elected to the Board of Directors of Physicians' Service, Inc., the Blue Shield Organization with headquarters in Columbus.

Fifth District

HERBERT S. ALDEN, Atlanta, spoke to the Negro Frontier Club of Atlanta on the subject of "Vitiligo", or lack of pigmentation in the skin. Dr. Alden praised Howard University (for Negroes) as an institution able to provide support to the solution of the problems of the skin.

RICHARD BLUMBERG, Atlanta, acting chairman of the Department of Pediatrics of the Emory University School of Medicine, addressed the Woman's Auxiliary to the Fulton County Medical Society at its February meeting. His topic was "Accidents Are the Chief Cause of Death of Children. Is There a Remedy?"

At the meeting of the Piedmont Proctologic Society held in Charleston, S. C., on March 17, 1956, two Atlanta physicians were guest speakers. EDGAR BOLING spoke on "Office Diagnosis and Treatment of Anorectal Conditions", and EARL RASMUSSEN's topic was "Modern Concepts of Management of Pilonidal Disease".

ROBERT L. BROWN, Emory University, was one of the guest speakers at the recent meeting in Atlanta of the Georgia State Association of Medical Record Librarians. He spoke on "Tumor Registry in Georgia". G. L. FORBES, JR., Atlanta, chief pathologist at the Georgia Baptist Hospital, addressed the group on "The Tissue Committee".

T. STERLING CLAIBORNE, Atlanta, was the guest speaker at the "civic night" dinner given by the Carrollton Pilot Club to start the annual Heart Fund Drive which the Pilot Club sponsored again this year. Dr. Claiborne is a past president of the Georgia Heart Association and has devoted much of his time and effort to its work since the Association was organized in Georgia.

McLAREN JOHNSON, Atlanta, president of the Fulton County Medical Society, has been made an honorary member of the Professional Service Representatives Association.

JAMES A. KAUFMAN and MICHAEL V. MURPHY, JR., Atlanta, were co-chairmen of the doctors' division for solicitation of funds in the Georgia

Heart Fund Drive in the Atlanta area. They were assisted by 100 other physicians.

B. L. SHACKLEFORD, Atlanta, was the speaker at a recent meeting of the Fifth District Practical Nurses' Association.

GEORGE A. WILLIAMS, Atlanta, was elected vice-president of the South Atlantic Association of Obstetricians and Gynecologists at the meeting held in Hollywood, Fla., January 29-February 1, 1956.

Sixth District

Mr. and Mrs. M. C. Sheffield of West Palm Beach, Fla., have announced the marriage of their daughter, Marie Wynnell of Augusta, to ALBERT R. BUSH, Dublin, on January 14, 1956, in Edgefield, S. C. Dr. Bush is associated with the VA Hospital in Dublin.

T. C. JORDAN, JR., Milledgeville, has announced the opening of an office for the practice of general medicine and surgery in Milledgeville. His offices are located in the Baldwin Hotel Building on South Wayne St. A graduate of the Medical College of Georgia, Dr. Jordan interned and served his residency at the Macon Hospital; he has practiced in Barnesville, Thomasville, and Florida.

The Dublin VA Hospital has had three additions to its staff recently. They are GRADY E. LONGINO, SAMUEL N. DULIN, JR., and FOLKE BECKER. Dr. Longino is a native of Atlanta and a graduate of Emory University and Emory University School of Medicine. Prior to coming to Dublin he was engaged in private practice in Atlanta. Dr. Dulin is originally from Elizabeth City, N. C.; he is a graduate of the University of North Carolina and George Washington University Medical School. Dr. Dulin comes to Dublin from the medical staff of the du Pont Company at the Savannah River Project. Dr. Becker, who will head the Physical Medical and Rehabilitation Service, was born in Brooklyn, N. Y. He is a graduate of Cornell University and Temple University Medical School. He is a veteran of World War II with the current rank of Commander (Retired), U. S. N.

J. P. WOODHALL, Macon, spoke at the recent meeting of the Sixth District Georgia State Nurses Association in Macon. His subject was "Nursing Care in Chest Surgery".

Seventh District

W. H. BENSON, Marietta, spoke to the Couples Club of the First Methodist Church of Marietta recently. Topic for discussion was the relationship between parents and their children. Dr. Benson is a graduate of Emory University School of Medicine and did post-graduate work at Columbia University and Mt. Sinai Medical Center. He also received psychiatric training in the Army.

W. HARVEY HOWELL, Cartersville, was the guest speaker at a recent meeting of the Cartersville Kiwanis Club. He spoke on "Bacteria versus Fungus", giving an account of the progress of medical science in the field of antibiotic drugs since the advent of penicillin in 1940.

R. D. WALTER, Calhoun, has just finished a two-year term as president of the Northwest Georgia Council, Boy Scouts of America, and has been elected the National Representative for the Northwest Georgia Council of the Boy Scouts of America.

GEORGE MARTIN WHITE, Rockmart, suffered a stroke last fall and is at present a patient in the Rockmart Hospital. This year marks the 50th anniversary of his medical practice. Dr. White came to Rockmart in 1910, after having practiced in Buchanan for four years after graduation in 1906 from the Atlanta College of Physicians and Surgeons. Dr. White was born in Haralson County and received his undergraduate training at Emory University. In 1909 he was married to Miss Eula McBride of Tallapoosa; the first Mrs. White died in 1918. He was later married to Mrs. Anne Calhoun Ferguson; and they now live at 107 Ivy Circle, Rockmart. He was the first chief-of-staff of the Rockmart-Aragon Hospital, a charter member of the Rockmart Rotary Club, a Shriner, and a director of the Rockmart Bank. He received the Selective Service Medal from President Roosevelt and Certificate of Appreciation from President Truman for voluntary and uncompensated services rendered his country for four years.

Eighth District

ARTHUR M. KNIGHT, JR., Waycross, was one of the featured speakers at a recent meeting of the Waycross Senior Woman's Club. He spoke to the group on "Mental Health Conditions", showing a film,

"City of the Sick", to illustrate his talk. Dr. Knight discussed the incidence of mental illness and mentioned new drugs used in the treatment of mental diseases.

WILLIAM C. RETTERBUSH, Valdosta, has recently been certified by the American Board of Surgery. Dr. Retterbush graduated in 1947 from the Ohio State University. He is now engaged in the private practice of surgery in Valdosta.

Ninth District

JOE J. ARRENDALE, Cornelia, has been elected to the Board of Directors of Physicians' Service, Inc., the non-profit Blue Shield Plan with headquarters in Columbus.

SAMUEL H. HAY, Toccoa, of the Toccoa Clinic staff, is now a diplomate of the American Board of Internal Medicine, having received his certificate February 10, 1956.

PAUL T. SCOGGINS, Commerce, was re-elected to the Board of Directors of Physicians' Service, Inc., at its annual meeting in Columbus in January. This meeting was also attended by ARTHUR G. SINGER, Toccoa, a member of the Board of Directors.

ARTHUR G. SINGER, Toccoa, spoke to the Rotary Club of Toccoa and told the members assembled of the dangers and slow progress being made in the fight against rheumatic fever. Dr. Singer is a director of the Georgia Heart Association and was speaking in conjunction with the drive being put on by the Heart Association to "Stop Rheumatic Fever".

Tenth District

An Augusta physician has been named to the Board of Directors of Physicians' Service, Inc., PIERCE G. BLITCH JR., who has been named for a three-year term.

A. W. DAVIS, Warrenton, has been appointed to serve as a member of the Social Security Board from the 10th District. The appointment was made by Governor Marvin Griffin.

A. DAN DUGGAN, Washington, has been selected to serve on the Board of Directors of Physicians' Service, Inc., the organization for the non-profit Blue Shield Plan for medical insurance coverage.

ALVA FAULKNER, Augusta, conducted a special study course in par-

ent education in Waynesboro in January. Dr. Faulkner, the former Miss Alva Humphrey, is a native of Waynesboro and a graduate of the Medical College of Georgia. She is now engaged in private practice in Augusta. Dr. Faulkner is married to JOHN A. FAULKNER, and they have two children.

JAMES GRANT and STUART PRATHER, Augusta, are now affiliated, on a part-time basis, with Claxton Hospital in Dublin. The two radiologists will be in Dublin every Wednesday afternoon to do X-ray work for the hospital.

RAYMOND F. PAYNE, Athens, spoke to the members of the Primary Child Study Group at their January meeting in Athens. Dr. Payne's topic was "Advice on Emotional Disturbances".

At the tuberculosis seminar held on February 1 and 2, 1956, RUFUS PAYNE, Augusta, spoke on "State Resources for Prevention and Treatment of Tuberculosis". Other speakers and their topics included: GRADY O. HAYNES, Augusta, and JOSEPH G. BOHORFOUSH, Atlanta, "Medical Care of Pulmonary Tuberculosis"; ROBERT C. MAJOR, Augusta, and Mark W. WALCOTT, Augusta, "Treatment of Tuberculosis Patients by Surgery"; and JOHN F. BUSCH, Atlanta, "Trends in Prevalence of Tuberculosis".

M. B. SELL, Augusta, has been named secretary of the newly expanded North Augusta (S. C.) Board of Health.

EDWARD O. WHITE, Madison, has announced the opening of a new clinic on Jefferson Street for the practice of general medicine. Dr. White graduated from the Medical College of South Carolina in 1946 and has been in general practice in Madison since 1949.

Everard W. Wilcox, Beaufort, S. C., Clinical Professor of Gynecology, Emeritus, of the Medical College of Georgia, addressed the medical staff of the U. S. Naval Hospital in Beaufort in December. The subject of his talk was "Tumors of the Ovary"; it was illustrated by lantern slides. Dr. Wilcox writes that he and Mrs. Wilcox have moved, in pieces, a great colonial house, circa 1825, from Augusta and rebuilt it on the bay in Beaufort. They have lived there since Dr. Wilcox's retirement several years ago.

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The JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and Copyright, 1956, by the Medical Association of Georgia, 875 West Peachtree Street, N. E., Atlanta, Georgia. Published monthly under the direction of the Council of the Association. Subscription rates: \$5 per year; 1 per single copy. Entered as second-class mail at the post office at Atlanta, Georgia, under the Act of March 3, 1879. Accepted for mailing for the general rate of postage provided for in Section 1103, Act of October 6, 1917, authorized November 14, 1928.



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COVER

With the dedication of this special issue to the Eugene Talmadge Memorial Hospital the cover shows the rendering of the architects, Gregson and Ellis, Atlanta. This is the sketch of what is now reality, as shown inside the book, see pages 151-157.

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MONDAY EVENING, MAY 14, ATLANTA BILTMORE HOTEL BALLROOM

• The Physician and THEOLOGY



Mr. Ralph McGill

"Theology and Medicine" is the topic of a panel discussion scheduled for 7:30 p. m. Monday night, May 14 at a general session of the State Medical meeting. *Atlanta Constitution* Editor Ralph McGill will moderate with two ministers, a physician, and a layman presenting views on this subject. Panel participants are: The Reverend Das Kelley Barnett, Austin, Texas; the Reverend Roy O. McClain, Atlanta; Dr. Robert B. Robins, Camden, Ark.; and Mr. Raymond C. Cropper, Macon.



Rev. Das Kelley Barnett



Rev. Roy O. McClain



Dr. Robert B. Robins



Mr. Raymond C. Cropper

• The Physician and The LAW

A "mock trial" demonstrating the rights and wrongs of medical testimony in a personal injury case will be presented immediately following the "Theology and Medicine" program, at 8:30 p. m. This demonstration has been presented by the AMA in many different cities and has been accorded a "must" for every M.D. Dr. George F. Lull will introduce this program and Mr. C. Joseph Stetler, AMA Law Department Director will preside. Dr. Ralph DeForest will act as the medical witness and Mr. Edwin Holman and Mr. R. G. Van Buskirk, AMA Law Department, will be the attorneys in the case.



Dr. George F. Lull



Mr. C. Joseph Stetler



Dr. Ralph E. DeForest



Mr. Edwin J. Holman



Mr. R. G. Van Buskirk

It's Annual Session Time Again...

APPLICATION FOR HOTEL ACCOMMODATIONS Medical Association of Georgia 1956 Annual Session May 13, 14, 15, and 16, 1956, Atlanta

A Housing Bureau has been established for your convenience in making your hotel reservations in Atlanta for the 1956 ANNUAL SESSION of the Medical Association of Georgia. Comparable room rates are listed. Use the Reservation Blank below. Please specify your first, second and third choice hotel. All requests for reservations should give: (1) anticipated date and hour of arrival; (2) date and approximate

hour of departure; and (3) names and addresses of all persons who will occupy the accommodations. ALL RESERVATIONS MUST BE CLEARED THROUGH THE HOUSING BUREAU. Since all requests for rooms will be handled in *chronological* order, you should mail your application as early as possible. All reservations will be confirmed. The Atlanta Biltmore Hotel has been designated as the Headquarters Hotel.

Hotel	For Two Persons			
	Single	Double Bed	Twin Beds	Suite
ATLANTA BILTMORE	\$6.00-10.00	\$8.00-14.00	\$10.00-14.00	\$15.00-50.00
GEORGIAN TERRACE	5.00- 8.00	7.00- 9.00	7.50-11.00	12.00-25.00
COX CARLTON	4.00- 6.00	6.00- 8.00	6.00- 8.00	15.00
PEACHTREE MANOR	5.00- 8.00	7.50- 9.50	8.50-12.00	15.00-28.00
DINKLER PLAZA	6.00- 8.50	7.00-11.50	13.00-15.00	12.00-35.00
HENRY GRADY	5.50-12.00	9.00-12.00	9.50-12.00	16.00-25.00
ATLANTAN	4.00- 5.50	6.00- 8.50	8.50-10.00	16.00
PIEDMONT	5.50- 8.00	7.00- 9.00	10.00-14.00	25.00
PEACHTREE ON PEACHTREE	5.00- 6.00	7.50- 9.00	8.50-10.50	10.00-15.00
GEORGIA	4.00- 7.00	6.00- 9.00	7.00-10.00	15.00-30.00

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Please reserve the following accommodations for me for the 1956 Medical Association of Georgia Annual Session:

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Treatment of Withdrawal Symptoms in the Management of Alcoholism

VERNELLE FOX, M.D., Atlanta, Ga.

TREATMENT OF ALCOHOLISM has always been difficult and frustrating. Many physicians do not accept the alcoholic as a patient, general hospitals refuse him admission, and insurance companies will not pay benefits during the hospitalization required for recovery from a severe debauch. The reasons for such an attitude are numerous, and some are valid. Although it is true that some individuals have no motivation to stop drinking and will not remain sober, there is also a large group who have a real potential for rehabilitation and restoration to normal life.

With better understanding of alcoholism, a good deal of assistance has now become available in the state through the services of local Alcoholics Anonymous groups and of the Rehabilitation Center of the Georgia Commission on Alcoholism, which provides both in-patient and out-patient treatment; from private psychotherapy, and in more realistic counseling by the clergy and lay groups. However, to be eligible for help from such sources, the alcoholic must be "dry" and in reasonably good physical condition, and must be willing to make use of the aid at hand. On the general practitioner or internist, therefore, devolves the responsibility of preparing the victim physically for reestablishment as a useful citizen.

Individuals who have been drinking continuously and who are not yet "ready" to become sober cannot, in my experience, be managed successfully without medication to relieve the tension and substitute for the artificial support provided by alcohol. The problems heretofore associated with treatment in the withdrawal phase may now be more easily solved as a result of the introduction of several new drugs, notably chlorpromazine and meprobamate, and certain of the nonbarbiturate hypnotics. A statistical evaluation of our results showed such encouraging progress that I have been prompted to describe our methods.

From the Peachtree Sanitarium, Atlanta, Georgia.

Materials and Methods

The entire series (Table 1) totaled 131 consecutive private alcoholic patients, studied during 208 admissions, with a hospital stay of at least two days, usually more. In each case the patient undertook treatment voluntarily. Males outnumbered females eight to one; the age range was 28 to 69 years, with an average of about 45 years.

The total series was divided into four groups. Supportive therapy including vitamins and minerals in high dosage was administered to all; fluids were forced by mouth. Although used only as a last resort, alcohol was permitted when insisted on, since experience has taught us that the patient will be more cooperative if he knows some alcohol is available. The individual was encouraged in each case to participate actively in a subsequent program for rehabilitation. Superficial psychotherapy was administered in moderate amount during hospitalization and was continued for varying periods after discharge.

Group 1 (controls) comprised a digest of the histories of previous admissions for 16 of the patients in Groups 2 and 3. The therapeutic program included medication with fairly large doses of barbiturates, chloral hydrate, paraldehyde, and, of course, alcohol. A variety of supplementary treatments was given, generally including intravenous administration of 50 per cent glucose with insulin, and occasionally ACTH.

The results are shown in Table 1. The average hospital stay for each patient was about four days. In accordance with the standard treatment then in use, each patient received an average of nine doses of a barbiturate, three doses of chloral hydrate, two doses of paraldehyde, and 15 ounces of alcohol per admission.

Group 2 represents our initial effort to work out an improved therapeutic program employing less hypnotic medication, since it has been our observa-

Group No.	Diagnosis	Total no. of patients	Total admnsn's for group	Average hos. stay each, admnsn's days	Hypnotics doses per patient per admission			Chlorpromazine per patient per admission average no. doses	Meprobamate per patient per admisn avg. no. doses	Alcohol per patient per admisn avg. no. ozs.
					Barbiturates	Chloral hydrate	Paraldehyde			
1 (controls)	Alcoholism with acute brain syndrome	16	62	4	9	3	2	0	0	15
2	Alcoholism with acute brain syndrome	15	17	4	4	2		10-25 mg. orally for total of 16-20 doses. Continued at least two weeks after discharge.	0	4
3	Alcoholism with acute brain syndrome	67	88	3	1	0	0	25-50 mg. intramuscularly until complete relaxation, then 50-100 mg. orally, for average total of about 18 doses.	0	4
4	Alcoholism with acute brain syndrome 31) Demerol addiction-chloral hydrate intoxication 1) Migraine-anxiety neurosis 1)	33	41	3	0	0	1 in 1 admission	Average 1 or 2 doses of 25-100 mg. intramuscularly in 22 admissions, and 10 doses 50-100 mg. orally in 36 admissions.	13 doses of 400-800 mg. orally	3
Total		131	208							

Table 1
TREATMENT OF WITHDRAWAL PHASE IN ALCOHOLISM

tion that most alcoholics experience a recurrence of the intoxication on use of the common soporific agents. Fifteen alcoholic patients received an average of 16 to 20 doses per patient per admission of chlorpromazine orally in low dosage (10 to 25 mg. three to four times a day); as a last resort, hypnotics or sedatives and alcohol were given as required. All of these patients were instructed to continue chlorpromazine for a minimum of two weeks after discharge.

Results in this group were encouraging. Less than half the usual amount of hypnotic drugs, including an average of four doses of the barbiturates and two of chloral hydrate, was required in this group, and the average amount of alcohol consumed by each patient during the withdrawal period was reduced to approximately one fourth of the amount demanded by the controls. However, the hospital stays were of approximately the same duration, the need for special nurses and restraints was not reduced, and the condition of the patient on discharge was about the same as for the control group.

We continued our efforts to improve the program, and to this end began to administer chlorpromazine by intramuscular injection as well as by mouth, employing larger doses. Thus, in *Group 3*, 67 alcoholics received chlorpromazine in doses of 25 to 50 mg. intramuscularly every four to six hours until complete relaxation was achieved (usually within 36 to 48 hours). Then the dosage was changed to 50-100 mg. orally every four hours, for an average total of about 18 doses. These patients had been consuming variable amounts of alcohol and had taken an assort-

ment of drugs for sedation for periods of a few days to several weeks or months, with an average of three to six weeks. One man had received sedatives every day for nine and one-half years.

Under the new regimen each patient was satisfactorily managed on an average of only one dose of barbiturate and about five doses of one of the newer nonbarbiturate hypnotics (Dormison®, 500 mg., or Doriden®, 250 mg.). Depressed persons received 2.5 mg. Desoxyn® with $\frac{3}{4}$ grain Gemonil®* after breakfast and lunch for the first few days of treatment. No patient required paraldehyde or chloral hydrate for sleep. Here again, less than one-half the total amount of hypnotics and sedatives formerly required was necessary for the group. We feel this explains, at least in part, the improved results achieved.

For *Group 3*, the average period of hospitalization was reduced by about one day, and the patient was rendered much more comfortable than formerly. Vomiting after the start of treatment became a very rare symptom. Almost all ate full meals and between-meal snacks from the time of admission; it was seldom necessary to administer fluids intravenously. The need for restraints and special nurses was eliminated, except for patients with delirium tremens. Thus the average cost of hospitalization per patient was reduced by about 50 dollars.

Not one patient in Groups 2 and 3 suffered convulsions after treatment was started, although four had had seizures just prior to admission, and five

*Gemonil gr. $\frac{3}{4}$ and Desoxyn 2.5 mg. Tablets provided by Abbott Laboratories.

had all the other manifestations of delirium tremens when admitted. In Group 3, most patients with delirium tremens cleared in 48 hours. However, hallucinations and agitation recurred eight and one-half hours after discontinuance of chlorpromazine in one man whose symptoms had completely disappeared following the first 48 hours of medication. For this patient an additional course of intensive treatment for 36 hours was necessary to control symptoms.

All patients in Groups 2 and 3 showed a markedly lessened craving for alcohol and required only about three to four ounces during the withdrawal phase, or about one-fourth the amount required in the control study (Group 1).

Side Effects

It soon became apparent, however, that some disadvantages attended intramuscular chlorpromazine treatment. Slight jaundice developed in one patient who had received 25 mg. three times a day throughout seven days of hospitalization and for two weeks thereafter (a total of 63 doses). Two had an allergic rash. All evidence of side reactions cleared on withdrawal of chlorpromazine and use of antihistamines. A Parkinsonian syndrome developed in three patients after seven to 10 days of medication, and hypotension and extreme weakness developed in three others. The dosage of chlorpromazine was reduced in all six, with prompt subsidence of symptoms. Almost 50 per cent of the patients receiving chlorpromazine in higher dosage complained of nasal stuffiness.

All those who received chlorpromazine by injection suffered pain and tenderness at the injected site, despite dilution of the drug with equal parts of water and procaine. Frank chemical cellulitis of the buttocks occurred in four patients, but cleared without abscess or slough on application of heat. Intramuscular medication, of course, increased the cost of hospitalization somewhat, but the additional expense was more than offset by the shorter hospital stay and need for fewer other services.

Another disadvantage of intramuscular chlorpromazine treatment was the very high incidence of dermatitis of the nurses' hands. This was a serious problem since skilled nursing is absolutely essential to successful management of the alcoholic patient, and few nurses are well trained in this field.

Other Methods Tried

Several other methods of treatment were then tried. Reserpine in a total dosage of 22.5 mg. intramuscularly in six hours failed to quiet a patient with delir-

ium tremens, although satisfactory results have been reported from others' use of smaller doses. Promethazine alone, in doses up to 50 mg. intramuscularly every four hours, was used in a few patients but was not strikingly successful. In a later part of this study (Group 4) promethazine** in combination with chlorpromazine and meprobamate proved more effective. Meprobamate,*** used singly and in low dosage, was tried, but the initial results were not dramatic; violently agitated patients were not controlled. A new plan of treatment was finally adopted.

Group 4. Thirty-three patients (29 males, four females), with an average age of 43 years, were seen in 41 admissions (one was admitted four times; one three times; and three were admitted twice). In 31 the diagnosis was alcoholism with acute brain syndrome, one was treated for Demerol® addiction and chloral hydrate intoxication, and one, for migraine with anxiety neurosis.

With use of meprobamate in larger amounts and oral doses of chlorpromazine, it was possible to obtain the desired results with less risk of complications. For each admission in this group, the patient received, throughout the usual hospital stay of three days, an average of 13 doses of 400 to 800 mg. meprobamate orally, in association with chlorpromazine. One or two doses of 25 to 100 mg. chlorpromazine were administered intramuscularly in 30 of the admissions, and an average of 10 doses of 50 to 100 mg. orally in 36 of the admissions. In 11 admissions oral administration of the drug sufficed, and in five, chlorpromazine was used by injection only.

The results with this method showed a dramatic improvement over those following any other therapeutic regimen previously tried. The patients in Groups 3 and 4 commented enthusiastically on how much better they felt at the termination of treatment. Some had been admitted a number of times previously and had been treated by a variety of methods. One stated that having "had everything," he considered this treatment the most effective of all. Whereas formerly the alcoholic unit of this institution was filled with boisterous, aggressive, violently agitated patients, as well as those exhibiting merely the common symptoms of intoxication, the department is now quiet and peaceful, resembling the medical floor of a general hospital. The nurses remark that on this regimen even the most troublesome patients are much easier to handle. In more than 50 per cent of admissions the patients sleep soundly for two to six hours after the initial dosage. At discharge on completion of the program, all are clear and calm.

No barbiturates or chloral hydrate were required for any patient in Group 4. One dose of paraldehyde was used in one admission. Four doses of one of the new nonbarbiturate hypnotics were administered

**Phenergan® Hydrochloride Tablets, Promethazine Hydrochloride, N-(2'-Dimethylamino-2'-Methyl) Ethyl Phenothiazine Hydrochloride; and Phenergan Hydrochloride Injection were supplied by Wyeth Laboratories.

***Equanil Tablets, Meprobamate, 2-Methyl-2-n-Propyl-1, 3-Propanediol Dicarbamate, was supplied by Wyeth Laboratories.

ed in each of four admissions. One 67-year-old patient with advanced cirrhosis and ascites received 23 doses of meprobamate, one intramuscular injection of 25 mg. chlorpromazine, and 20 doses of 12.5 mg. promethazine by mouth during his hospital stay of seven days. Agents other than chlorpromazine were used because of the degree of liver damage present.

The average amount of alcohol required per admission by each patient in the withdrawal phase was three ounces—only one-fifth the alcohol necessary for the patients in the control study.

The marked reduction in consumption of alcohol was the result of voluntary abstinence. Such change in attitude served to eliminate much of the resistance and hostility customarily encountered during the attempts of the therapist to strengthen in the patient a will to stop drinking, and it substantially aided the effort to fix responsibility for sobriety within the individual himself.

It is felt that a larger percentage of patients in this group showed good adjustment at the time of discharge than those treated with older methods. For them it is possible that prognosis may be more hopeful for long-term rehabilitation.

With use of meprobamate, thus permitting fewer intramuscular doses of chlorpromazine, none of the side effects were observed that had complicated treatment in Group 3.

Summary

The new tranquilizing drugs, chlorpromazine and meprobamate, were studied in a comparative investigation of modern methods for management of the withdrawal phase in alcoholism. The series totaled 131 consecutive private alcoholic patients, divided into four groups, and treated in 208 admissions. Males outnumbered the females eight to one; the average age was 45 years. All received the usual supportive treatment and superficial psychotherapy. Results were compared on the basis of length of hospital stay; need for special nurses, restraints, barbiturates, and other hypnotics; the amount of alcohol consumed throughout withdrawal; and the condition of the patient on discharge.

For *Group 1* (controls) the average hospital stay was about four days. The patients received, at each admission, an average of 14 doses of the standard

hypnotics, including barbiturates, chloral hydrate and paraldehyde, and 15 ounces of alcohol.

In *Group 2*, chlorpromazine was administered orally in low dosage for an average of 16 to 20 doses per patient per admission. Hypnotics were required for this group in less than half the amount previously used and alcohol in about one-quarter the usual dosage. The hospital stay and need for special nurses and restraints were not reduced; the condition of the patient on discharge was about the same as formerly.

In *Group 3*, chlorpromazine was administered in larger doses (25 to 50 mg. every four to six hours intramuscularly, and 50 to 100 mg. orally every four hours), for a total of about 18 doses. The hospital stay was reduced by one day, the patient was more comfortable, and fewer special services were required. Less than half the usual amount of hypnotics (generally the newer nonbarbiturate agents) and one-fourth the usual amount of alcohol were required. There were no convulsions or vomiting after start of treatment; and no need for restraints or special nurses, except in patients with delirium tremens (the duration of delirium tremens was greatly curtailed). The average cost per patient per admission was thus reduced by about 50 dollars.

Chlorpromazine treatment, however, was attended by undesirable side actions when given by frequent intramuscular injection or in very high dosage levels. Pain and tenderness at the injected site and, in some patients, cellulitis occurred after intramuscular injection. Contact dermatitis of the hands, induced by the drug, was a serious handicap to the nurses. Meprobamate alone was substituted but did not control the patients adequately.

In *Group 4*, comprising 33 patients, meprobamate was administered in larger doses in association with fewer doses of chlorpromazine by injection or by mouth, or both. This was much more satisfactory than all other ways tried. The average hospital stay was three days; no barbiturates and only one-fifth the amount of alcohol used in the control series were required. None of the previous troublesome side actions were encountered, and it was believed that a larger proportion of the patients made a good adjustment, with greater accessibility to psychotherapy.

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Conservatism in Obstetrics

S. A. COSGROVE, M.D., Jersey City, N.J.

“CONSERVATISM” AND “RADICALISM” are very generally and rather loosely in use regarding various forms of therapeutics, more especially the conduct of labor. The definition of conservatism is a kind of stand-pat-ism, an allegiance to old-established practices, an unwillingness to depart from well known procedures and embark on new and untried methods and practices. Radicalism is defined as a disposition to start from the root of things. Its usual implication is to significantly and rapidly change the practices deriving from the root or basis of the matter being considered or prosecuted.

But conservatism and radicalism are not of themselves fixed and immutable values. There is constant shifting of their meanings from time to time. Certainly on the political front, for instance, the meaning of conservative and radical as applied to national policies and practices would be very different today from even so recent a period in our national history as the early thirties of the twentieth century. Likewise in my own nearly 50 years in the practice of obstetrics, what would have in the beginning constituted extreme radicalism might well be at least partly embraced in the conservative field today, whereas some of the commonplace practices of the earlier period would today be considered criminally dangerous. Therefore both terms must be used in a more or less qualified sense. Conservatism should never be so hidebound as to be impervious to progressive inclusion of well-tried more radical practices. Radicalism should never be so exuberant as to be blind to the value of more conservative thought and attitudes abundantly justified by ages-long experience.

At any point in time, however, in relation to obstetrics the conservative thinker is impressed with the fact that the Almighty is the most experienced and the best accoucheur of us all; that the physiological processes of labor, in the vast majority of cases, are preferable to any man-devised wide departure therefrom, with reference to the welfare both of mothers and babies. He believes therefore that the unnecessary obtrusion of artificial substitutes for that process is unwarrantedly radical. The operation

of the physiological process will result in the highest degree of desirable results in more than 90 per cent of all labors.

On the other hand, the conservative thinker will recognize that not every labor is physiological or capable of successful termination entirely by the physiological mechanism thereof. When cases are not so capable of physiological evolution and termination the obstetrician of judgment may elect procedures which on the face are more radical than certain other procedures possibly applicable to the situations in question. So much is this so that relatively recent opinion and practice would seem to be shifting from a wholly conservative basis, or what would formerly have been considered a conservative basis, to a much more radical approach.

On the other hand, the conservative will resist an exaggeration of radical practices in the endeavor to permit the physiological evolution of labor to proceed without interference as often as he can. How shall one judge when the physiology of labor ceases to be adequate and resort to artificial assistance be necessary?

There is a physiological dystocia, so to speak, which almost invariably exists in the size-relationship between the inlet of the pelvis and the baby's head or other presenting part. This natural dystocia makes it necessary for the head to be accommodated in size to the passage by the process of molding. By molding is meant the lateral squeezing of the head and its change in shape, in a degree sufficient to permit it to pass through the inlet of the pelvis. This phenomenon is the crux of the success of the whole labor.

The force of the uterus exerted during the first stage results first in a compacting of the fetus as a whole by flexion of the torso of the baby, and more particularly the flexion of the head upon the torso. Beyond this, the entire power of the contractions is taken up, or absorbed, by the process of molding the partly plastic head. The degree of dystocia varies from almost none to such a high degree of disproportion as to be pathological and to make delivery through the birth tract absolutely impossible. The quality and frequency of the contractions of the uterus during the period of molding vary considerably

This paper was presented as the Seventh E. C. Davis Memorial Lecture, Atlanta.

in individual cases. There is therefore a great variance in the duration of this first stage. The end-point of molding is called engagement.

Engagement is defined as the point in the molding or accommodation of the head to the inlet whereby the head fits the inlet. Expressed in somewhat different terms, it is the correspondence between the plane of the greatest diameter of the head as it approaches the inlet and the plane of the least diameter of that inlet. Not until this end-point of perfect engagement is attained can any of the further phenomena of labor take place. It would therefore seem perfectly obvious that the attainment of full engagement, as herein specifically defined, marks the end of the first stage of labor. Engagement is the sole and the most important result obtained by the expulsive forces operating to press the fetus through the birth passage, against the resistance represented by the inadequacy of size of that passage to accommodate the entrance of the baby without such molding. It has heretofore been taught that the full dilatation and retraction of the cervix uteri marked the end of the first stage of labor, the assumption being that the cervix itself represented the most important resistance to the descent of the baby into the birth passage. Hence it has always been conceived that the failure of the cervix to dilate is *per se* frequently the cause of labor arrest. If this concept be not true, then what is the relation of the cervix to labor? Ordinarily its physiological behavior would result in the majority of cases in the effacement and dilatation of the cervix proceeding more or less concomitantly with the molding of the head. Thus the attainment of complete engagement and complete dilatation and retraction of the cervix would approximately coincide. In normal cases it is hardly more than an academic question as to which end-point, that is, full engagement of the head or full dilatation of the cervix, actually does mark the end of the first stage.

But when there is a greater degree of delay and trouble in the accommodation of the head to the inlet, the relation of the cervix to labor progress varies. In some cases the cervix may fully dilate and retract when the head is quite obviously still impacted in the inlet, that is, incompletely engaged. Occasionally the dilated cervix seems to lie as a loose cuff around the head while the head still lacks complete accommodation to the inlet and hence any possibility of progressing through it. In either of the preceding situations, no one would dispute the fact that the difficulty lay in the cephalopelvic relationship and not in the behavior of the cervix. But the cervix does not very often do either of these things. Rather, there is simultaneous cessation of accommodation of the head

to the inlet and dilatation of the cervix. Here it may appear superficially obvious that the head cannot come through until the cervix is out of the way. On the basis of this belief, manual or instrumental dilatation of the cervix has in the past been extensively employed. The head has been dragged by forceps or version attempted through incompletely dilated cervixes; the cervix has been incised by the method of Duhrsen and other technics.

I believe that all of these procedures are wrong. They are based on the false assumption that it is the rigid or non-dilating cervix which is responsible for the rest of the baby's progress. I very strongly believe that the cervix possesses only a relatively simple and entirely passive role in labor. In other words, the cervix by itself, except when diseased by extensive cicatrix or neoplasm, is never capable of arresting labor. In reality those cases in which the cervix does appear to arrest labor are those in which the incomplete molding of the head has not yet resulted in fullest engagement. Further descent of the head is therefore arrested, and by that arrest is prevented from pushing the cervix out of the way. As soon as engagement has been achieved and descent begins, the cervix is forced out of the way.

Now I will concede that when arrest of the head in the inlet due to incomplete molding is allowed to obtain too long, the head does not push the cervix out of its way. Then there may ensue secondary changes of congestion, edema, and even more serious pathology of the cervix constituting a secondary diseased condition thereof which complicates the situation. The way out of this, however, is very rarely to attack the cervix itself. Much more frequently the impasse should be resolved by resorting to cesarean section before this situation has time to develop. This concept of the behavior of the cervix emphasizes the common sense of accepting the engagement of the head rather than the dilatation of the cervix as the end-point of the phenomena constituting the first stage of labor.

Determination of Engagement

It therefore becomes important to be able to determine engagement. This can be diagnosed in only one way, full-handed vaginal exploration. For instance, the very common teaching that the station of the head at zero, that is, lying in the line between the ischial spines, denotes engagement is perniciously wrong. Only in the most favorable cases, where the need for molding to accomplish engagement is minimal, will this criterion have validity. In those cases in which there are higher degrees of disproportion, necessitating increased molding to accomplish engagement, there will be such a lengthening of the head as to completely invalidate the relation of the peak of the head to the interspinous line as a measure of en-

gement. Indeed the peak of the head may be well down in the pelvis, almost on the perineal floor without engagement's having been fully accomplished.

What seems to me to be another fallacy in common teaching is that there is a fixed or standard time relationship to the several phenomena and stages of labor. It is especially widespread practice to relate management to a two hour limit of the second stage. I cannot too strongly emphasize that there is no time limit on the duration of anything connected with labor!

Management

When forceps were introduced, babies had to be delivered through the vagina in almost all cases. While cesarean section had been in use at a much earlier date, its danger was so extreme as to almost completely negate its use in the solution of the ordinary problems of labor. This continued to be true up until about the beginning of my own lifetime when the acceptance of antisepsis and asepsis in all branches of surgery began to liberalize the use of cesarean section to the point that in the last quarter century perhaps the freedom of resort to it has been quite extensively abused. Certainly its increased availability has very considerably changed the philosophy in practice in the employment of forceps. Up until less than 50 years ago the forceps had to be relied upon in many cases to complete the molding and therefore the engagement of the head. This necessitated depending upon forceps for the function of compression. This function of the forceps inevitably carried with it great risk to the integrity of the content of the fetal cranium, and many babies were killed or damaged by their use in this manner. The necessity for such use no longer exists. The only functions that are proper today are traction and rotation. It must not be forgotten, however, that inevitably there is an inadvertent risk of their actually acting as compressors. This fact must be constantly in the obstetrician's mind in using them.

Use of Forceps

So much has the function of the forceps changed that universally in American practice application of high forceps to the wholly unengaged head has long since passed any possible legitimacy. Moreover, it is becoming increasingly recognized that the difficult use of mid forceps, with the danger of compression of the baby's skull and the danger of extensive damage to the mother's soft parts, should also be almost wholly outlawed. Recourse should be had to cesarean section in many cases in which mid forceps would have been considered good practice even up to relatively recent times. This leaves then the proper employment of forceps nowadays to their low application only, and that means actually low. It does not mean such an equivocal designation as "low-mid"

forceps. Indeed, Jeffcoate, a leading English authority, warns that outside of hospitals, the forceps should not be applied until the head is visible in the introitus. Eastman has laid down very similar conditions. This is not a bad rule to follow in or out of hospitals. He, like many American operators, believes that the employment of low forceps is quite generally a salutary procedure in the interest of the mother and the baby. I am not so enthusiastic about the actual salutary effect even of low forceps, in the majority of cases. I believe that once engagement has been successfully accomplished, the descent and rotation of the head through the mid-pelvis will generally be accomplished to a degree permitting the restriction of the use of forceps to a head lying definitely in the introitus and bony outlet of the pelvis. Even here I believe, however, that the pressures on the intracranial contents of the fetus are better distributed by the natural forces of labor, and therefore better tolerated, than are the pressures dependent upon the forceps. The introduction of unyielding steel instruments into the birth tract, there to occupy badly needed space, and to increase by the thickness and curvature of the blades the measurements of the baby's head seeking to pass through it, is undesirable unless necessitated by actual mechanical conditions such as contraction of the bony outlet, unusual rigidity of the pelvic floor, and unresolved transverse or posterior positions of the occiput.

In the latter situations the second legitimate function of the forceps, that is, rotation, finds much usefulness. But even these procedures should be reserved until the head is well down in the pelvis because this is the level at which such rotation physiologically occurs. To attempt the extraction of such heads before one is assured of complete engagement and a station of the head well down in the pelvic passage is to invite unnecessary danger.

Even in the simplest low forceps extraction, the instrument should be used as tractors only to an extent necessary to accomplish overcoming the obstructive factor, whether that be a rigid coccyx or a narrowed subpubic arch. Such objective of the use of forceps having been accomplished, the instrument should be immediately removed in order to permit the head to avail itself of the maximum space possible. It is remarkable how the removal of the blades before the birth of the head so signally expedites the full expulsion thereof by the mother's voluntary effort.

I have concentrated much of this discussion on the most important condition for the use of the forceps, namely, the complete accommodation of the head to the pelvic inlet. A secondary, but very important condition, is the full dilatation and retraction of the cervix, not expressed in definitive measurements as so many centimeters or so many fingerbreadths, but

as relative to the head itself. A fully dilated and retracted cervix should be drawn up above the head so that it cannot be felt by the examining fingers in the vagina without pushing them up past the head and palpating the cervix well above the maximum plane thereof. To apply the forceps in any other situation is to inevitably invite lacerations of the cervix with grave risk to the mother.

The forceps are provided with what is called the pelvic curve designed to more or less accurately correspond to the curve of the axis of the pelvis. Formerly it was considered most important to have these two curves correspond, that is, to insert the forceps in such a way as to make them lie in proper relation to the pelvis. Today it is, I think, universally considered much more important to have them correspond to the degree of rotation of the baby's head, in order that the traction exerted by them does so on the bimalar diameter of the head avoiding any pressure on the more vulnerable parts of the calvarium. To do this, very careful and accurate diagnosis of the position of the head must be established. Again, this can be accomplished in some cases only by full handed exploration by vagina of all the landmarks of the baby's calvarium and face. The introduction of two fingers into the vagina, the palpation of one fontanelle, and the assumption of the position of the head from such careless observation is productive of very frequent and costly error.

To recapitulate the present day indications for forceps: their use to wholly accomplish molding and engagement as in the old high application should be absolutely outlawed; their use to partly accomplish molding and engagement as in the so-called high-mid or mid applications, should be considered relatively outlawed and undesirable. There will, of course, remain in this category a fringe area in which the ideals just stated will have to be compromised. These cases include those in which spontaneous anterior rotation of the posterior occiput or chin fails; those in which there is arrest of the head presenting by the occiput in transverse position; some cases in which pelvic contracture in the mid-plane may cause arrest of labor; a very few cases in which urgent danger to the fetus or to the mother necessitates prompt delivery at a possible sacrifice of optimum conditions for fetal or maternal survival. This leaves then the principal indication for forceps the arrest of labor with the head very low in the parturient canal either because of fetopelvic disproportion inherent in the excessive elongation of the head by molding, or by pelvic inadequacy inherent at this level; by relative failure of the expulsive forces; or by the valid desirability of expediting the delivery for causes other than the obstetrician's hurry, his convenience, or the importunity of the patient or her family.

This does indeed seem like a very narrow restriction of the field of usefulness of the forceps. But unless their use is carefully so circumscribed, the chances of their abuse and very dangerous results of that abuse are great even in hospitals and in the hands of qualified experts. This danger is very much increased when obstetrics has to be practiced outside of hospitals by men whose training and experience do not qualify them as experts. I do not wish to be misunderstood. Not every operator who has the advantage of doing his work in a well-equipped and organized hospital is necessarily thereby a qualified expert. On the other hand, it goes without saying that there are many men practicing without such advantages who bring to their work high degrees of conscience, judgment, and technical skill.

Use of Time

Does all of this connote that there is no middle ground between the relatively innocuous low forceps extraction and the acceptance of high rates of cesarean section? Not quite. It does mean, however, that the expert working under the most nearly ideal conditions must engage in an extension of this very restricted use of the forceps only with mature judgment and very definite trepidation and care. He who has to attempt such extension outside a good hospital environment must be even more reluctant and careful not to exceed the limits of the ideal use of the forceps. What are such individuals to do then with cases which are not progressing normally wherever they are being handled, especially if they are being handled in environments where recourse to cesarean section is extremely difficult or impossible? The only answer is time, the ancient and greatest ally of the obstetrician. There are many classic references extending back through the centuries attesting to the wisdom of full exploitation of time by the obstetrician in solving, as it is capable of doing, the vast majority of his problems in delivery. In doing so, certain of the more modern resources of medicine are at his command to make his dependence on time something very different from callous indifference to a patient's suffering or helpless ineptitude in his management of cases. The armamentarium available to him today includes a great variety of relatively safe analgesic and anesthetic methods for the protection of his patients against exhaustion, both psychic and physical. Sulfonamides and antibiotics make available to him potent means of fighting infection. The means of employing adequate quantities of water, salt, and sugar by parenteral routes are now available to him in such forms as to make their use possible in most isolated environmental situations for the purpose of protecting nutritional balance. The use of these resources permits the obstetrician to manage even difficult cases with minimal risk to the mother over a long period of

time without recourse to dangerous artificial interference.

It cannot be denied that such management may occasionally connote the intrapartum loss of a baby. I do believe, however, that this danger is definitely less than the danger of injury to babies by unnecessary and unwise artificial interference. Certainly the mothers are better off to be spared the sometimes very dangerous results depending on traumatizing artificial manipulation.

Cesarean Section

In relation to those cases in which labor is arrested by failure of complete engagement of the head and by outlawing the application of forceps to such situations as I have indicated as desirable, there will, of course, be a somewhat increased incidence of cesarean section as compared to older standards. I do not believe, however, that in properly organized and conducted hospital services the actual percentage incidence of cesarean section is going to become inordinately high. It may be somewhat higher than it has been in the past but certainly will not approach the astronomical figures already current in some institutions. Nor do I greatly care about percentage incidence. The important consideration is to be sure that each cesarean section is chosen with reference to the best interest of the particular mother and particular baby being handled at the time that section is chosen. Some of these sections will undoubtedly be performed in situations in which formerly difficult forceps or version might have been more or less successfully used. I am sure, however, that careful scrutiny of the maternal deaths, the maternal invalidism, and the fetal loss attending these procedures under the given circumstances would justify relegating them to obsolescence.

Such an increased primary use of cesarean section immediately brings us face to face with a dilemma. How shall women who have once had a section be handled in future deliveries? Very many practitioners, including some individuals whose eminence of attainment entitles them to the highest respect, believe in the dictum "once a cesarean section, always a cesarean section."

Suppose of 100 primigravidae five were sectioned. Suppose four out of those five women again became pregnant and were again sectioned. Again suppose that three of the five once more were sectioned for a third delivery. Then the percentage of the original 100 primigravidae who were operated would have risen to 12 per cent instead of five per cent. This illustrates simply enough the inordinate proportions which slavish following of the "once a cesarean section" dictum would result in. But there is increasing recognition both in this country and foreign countries that this dictum is not true. To the end of 1954,

there were 158,498 deliveries and 5,407 cesarean sections at the Margaret Hague Maternity Hospital. In a recent review of a consecutive series of 500 of these sections, Robert Cosgrove found the incidence of vaginal delivery following those sections to be 37.8 per cent. This figure coincides closely with the experience of The New York Lying-In Hospital and other leading clinics in various parts of the country. A much higher proportion than this has been recently reported from Chile. If this incidence is applied to all of the cesarean sections performed in our hospital, 2,044 women have been delivered once or several times by vagina after an original cesarean section. We believe very definitely that it is better for a woman if she can to deliver by vagina than to have a repeat cesarean section. However, this must be managed by experienced competent obstetricians in exceptionally well equipped and organized clinics. For the bugaboo which those men fear who deny their patients the opportunity to deliver by vagina following cesarean section is rupture of the uterus.

We concede that the danger of rupture of the uterus does exist in permitting women to deliver by vagina following cesarean section. We have had such ruptures occur in our clinic. In their discussion, however, the difference between calamitous rupture with the extrusion of the whole conceptus into the mother's abdomen with most dangerous hemorrhage and with the inevitable death of the baby should be distinguished from incomplete ruptures where the original cesarean section scar has probably had a dehiscence occurring in the original period of healing of that incision. These ruptures do not involve the peritoneum, do not result in the extrusion of the whole conceptus into the mother's abdomen, and offer little risk of loss of babies.

The probability of the first or calamitous explosive ruptures of the uterus attends in our experience the so-called classical type of cesarean section. We have been so impressed by this that that type of operation is practically not used in our clinic except under certain very special conditions. We regularly use and infinitely prefer the transverse lower segment type of operation. Only this type of operation is confined to the thinned-out lower segment, and does not invade the active thick corporeal segment of the uterus. We have had following previous section eleven complete ruptures of the uterus, and twenty-two incomplete ruptures. This in comparison to the number of women who have delivered by vagina following cesarean section is 1.1 per cent. One only of these women has died. This in relation to the number of women who have delivered by vagina after cesarean section is 0.05 per cent.

It is thus seen that the greatest risk, perhaps the

only risk attending the practice of giving women the opportunity of delivering by vagina after cesarean section, is very very small, and that the lethal hazard to those women in properly organized clinics is almost microscopically small. This then represents a conservative tendency as opposed to the much more radical subjection of women to repeated operations because they have had previous ones. This conservative practice we believe is superior to the more radical one. Such an outstanding authority as Dieckmann, most authorities on the Pacific coast, and other specialists in all parts of the country do not agree with us.

But the use of repeat cesarean section at an elective time, more or less prior to the onset of spontaneous labor, is by no means innocuous. Robert Cosgrove found that in relation to the total number of repeat cesarean sections in our material, there were six maternal deaths, whereas there was no maternal death incident to vaginal delivery following original cesarean section and but one maternal death following the rupture of a scar of a previous cesarean section. The proponents of this practice insist that the uterus is incapacitated by an original section. How much more is it incapacitated by repeated insults of the same kind. On the basis of this consideration which is apparently recognized by such practitioners, they must resort relatively early in the history of multigravidity to sterilization to prevent further repetition of this damage. This, of course, necessarily limits the fecundity of these women.

Nor is the fetal risk of the practice of repeat cesarean section negligible. Many reports deal with the almost inexplicable high fetal mortality of cesarean section *per se* even in those cases in which the operation is not done for placenta previa or abruption of the placenta, or other indications which of themselves determine fetal death. Moreover, elective repeat section necessarily is employed before the onset of labor. How may one accurately calculate the degree of maturity of any fetus. If one is not able to do so then necessarily some of these fetuses are delivered early enough in gestation to constitute a serious threat to fetal survival due to immaturity. In our own complete ruptures three occurred prior to the onset of labor, one as early as the 34th week of gestation, another at 37 weeks. Certainly in both these cases a plan to reoperate a short time before the onset of labor

would not have been in time to prevent these ruptures.

Those of us who subscribe to the practice of allowing a woman to attempt to have her baby by the normal passages in spite of having once had a section for whatever indication, do so in the belief that on the basis of not only our own experience, but that of many other leading clinics, cesarean section broadly is not as safe as vaginal delivery. The safety factor is at least 2 to 1. Vaginal delivery does not limit the mother's fecundity. Prior to delivery in subsequent pregnancies the mother's psychic approach to her forthcoming experience is generally very much better if she understands that there is a possibility of her not requiring another cesarean section.

Summary

1. I have tried to show that in general conservatism is preferable to too great radicalism in obstetrics. But there is a constantly shifting meaning to these terms so that from time to time the significance of them will vary.

2. It is emphasized that engagement of the presenting part to the inlet of the pelvis is the crucial end-point of every labor. It is urged that this end-point be recognized as terminating the first stage of labor rather than the amount of dilatation of the cervix.

3. Much of the conservative shift in the management of labor is concerned with the use of forceps. The proper role of forceps in this modern concept is very largely restricted to use of them only when the head is very low in the pelvis.

4. The importance of complete retraction and dilatation of the cervix in the use of forceps is insisted upon.

5. The outstanding value of time to permit the evolution of physiological labor is stressed with absolute insistence on the impropriety of limiting the time necessary therefore with relation to any stage of phenomenon of labor.

6. The somewhat increased use of cesarean section resulting from the lessened use of forceps is admitted and discussed. It is pointed out that following generally the dictum of re-sectioning of cases that have been sectioned is unnecessary and deleterious in good labor environment and the reasons for this are set forth.

2787 Hudson Boulevard

Do You Know?

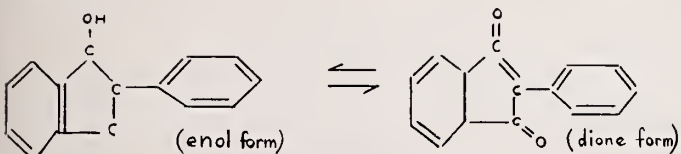
Approximately 1,930,000 workers in the United States were killed or disabled by on-the-job injuries during 1955, a 4 per cent increase over the 1954 level.

Work deaths last year totalled 14,200, an increase of 200 over the previous year but substantially below any other year since estimates began in 1936.

Phenylindanedione-- A Deserving Anticoagulant

BYRON F. HARPER, M.D., and RICHARD JOHNSON, M.D., Atlanta, Ga.

PHENYLINDANEDIONE, or Danilone, as marketed in the South, is 2-phenylindane-1, 3-dione ($C^{15}H^{10}O^2$) and has the following chemical structure.



History

In 1944 Kabat, Stohlman, and Smith of the U. S. Public Health Service described the effect of certain indanedione derivatives on prothrombin levels in animals.¹ Soulier and Guegen, in France, about 1947, reported the use of phenylindanedione clinically as an anticoagulant.² Jaques, in Canada, stimulated further interest in this substance by demonstrating that its effect on the prothrombin time was more prompt than that of dicumarol.³

Material

Phenylindanedione was used in 42 cases divided as follows:

Thrombophlebitis	19
Coronary Occlusion	18
Coronary Insufficiency	5

We were able to utilize 33 of these cases in computing the rapidity with which phenylindanedione comes into the therapeutic range. Five were omitted in this computation because of inadequate laboratory records and because of inadequate dosage on admission to the hospital. Ten to 30 per cent was taken as desired therapeutic level.

Advantages of Phenylindanedione

1. *Rapidity of Action.* Phenylindanedione is approximately twice as fast in reaching therapeutic levels as is dicumarol. The time required for all our cases to reach 30 per cent averaged 41 hours. However, using the cases in which near adequate dosage was given (i.e. at least 100 mg./12 hrs.) we found that the average time required to attain therapeutic levels was less than 36 hours.

Unlike two cases reported by Blaustein,⁴ and discussed by Wright,⁵ none of our cases were completely resistant. All cases reached therapeutic level when enough of the anticoagulant was administered. We had four cases that required 72-96 hours to reach

therapeutic level, two of these cases required 200 mg. a day to sustain therapeutic levels. All other cases were maintained on 150 mg. or less per day. The average daily dosage was 112 mg./day. Thus, it is our contention that every case should be started on 100-200 mg. of phenylindanedione.

In many hospitals one is unable to obtain a baseline prothrombin level until many hours after admission. To save valuable time, we believe it is safe to give the patient 100-200 mg. of phenylindanedione at the time of admission unless there is suggestive cardiac failure or liver disease. In our series of cases we had no patient with enough liver disease or cardiac failure to show a low initial prothrombin level.

2. *Low Toxicity.* Blaustein⁴ reported less than one per cent hemorrhage in his series. We had none in these 42 cases. Since reporting these cases we have had one instance of prolonged menstruation which ceased after the drug was withdrawn. Several of the patients noted orange discoloration of their urine. This discoloration will occur anytime the urine is alkaline while the patient is on this drug. There were no other toxic signs noted.

3. *Predictability.* We found the drug very predictable once daily dosage was ascertained. Blau-

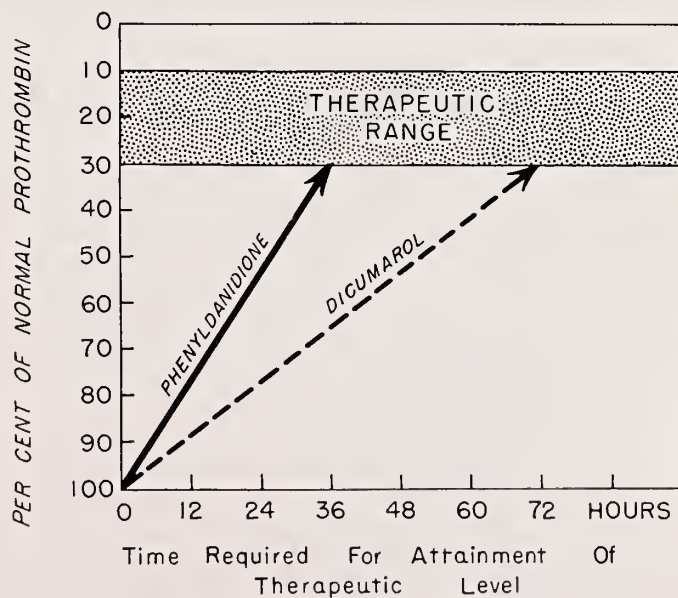


Figure 1. Per Cent of Normal Prothrombin.

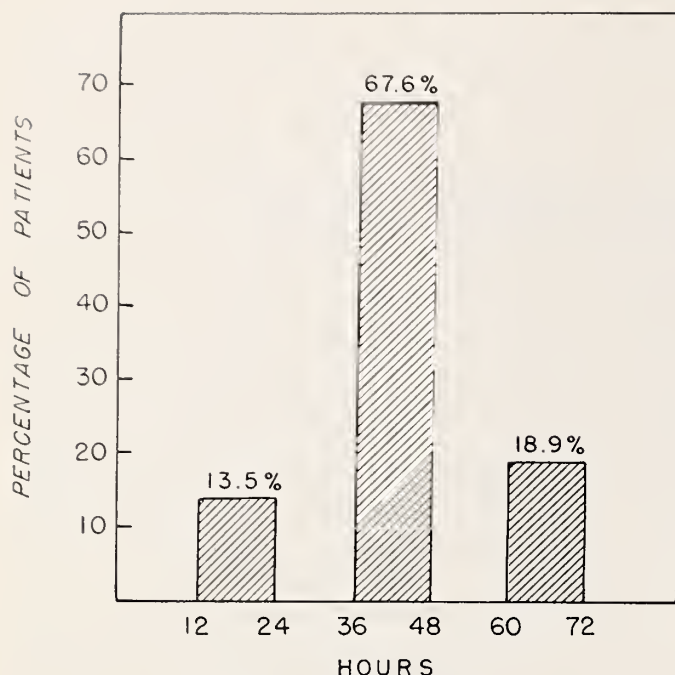


Figure 2. Percentage of Patients.

stein,* in his series had a few early cases in which wide swings of the prothrombin time-curve were encountered. This did not prove true in our series.

We had five patients which were readmitted to the hospital. The drug was repeated each time. All five of these patients received approximately the same average daily dosage on both admissions to the hospital, (i.e. if the patient required 100 mg. a day to sustain his therapeutic level of phenylin-

danedione on the first admission, on the second admission the requirements were the same—never deviating more than 25 mg. per day). This should prove of advantage in chronic cases where only infrequent prothrombin checks are possible.

As stated above we had no cases of absolute resistance to the drug.

Conclusion

In conclusion, it is our opinion that the advantages of this drug, phenylindanedione (danilone, hedulin*), which make it a deserving anticoagulant are:

1. Rapid onset
2. Low toxicity
3. Predictability

683 Lee Street, S. W.

Addendum

In approximately 75 other cases treated with phenylindanedione since this paper was given, the average time necessary to obtain therapeutic range averaged less than 36 hours.

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4. Blaustein, Ancel, et al., *Amer. J. of Med.* Vol. 14 Jan.-June 1953, p. 704.
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*Name under which marketed in the North, East, and now South.

Selective Service System Classification of Special Registrants in Class V-A

1. Paragraph (q) of section 1650.11 of the Selective Service Regulations has been amended to read as follows:

"(q) (1) A special registrant shall be placed in Class V-A if he has attained the thirty-fifth anniversary of the day of his birth and also has applied for a commission in one of the armed forces in a medical, dental, or allied specialist category and has been rejected for such commission on the sole ground of a physical disqualification.

"(2) A special registrant shall be placed in Class V-A if he has attained the forty-sixth anniversary of the day of his birth unless (i) he is on active military service in the armed forces and is in Class 1-C, or (ii) he is performing civilian work contributing to the maintenance of the national

health, safety, or interest in accordance with the order of the local board and is in Class I-W. Except as is otherwise provided in this subparagraph, every special registrant who prior to attaining the forty-sixth anniversary of the day of his birth has been classified in some other class shall, as soon as practicable after attaining the forty-sixth anniversary of the day of his birth, be reclassified into Class V-A."

2. In order to obtain accurate availability information, local boards are requested to classify in Class V-A as soon as possible, and no later than March 31, 1956, all special registrants who are now eligible for such classification under paragraph (q) of section 1650.11 of the regulations, as amended.

The

Eugene Talmadge Memorial Hospital Augusta, Georgia

Foreword

EDGAR R. PUND, M.D., Augusta, Ga.

FEW MEN ARE SO WELL qualified to speak of the "Evolution of the Talmadge Hospital" as G. Lombard Kelly. From his years as a student of medicine soon after the time of the tumultuous Flexner Report; the years spent in the anatomy classroom when he saw conditions become more crowded as time progressed; the interim years, when as Superintendent of the University Hospital he observed the growing paucity of clinical material for upperclassmen; and then as Dean and eventually as President, he was able to keep his fingers on the pulse of every phase of the medical college.

During the four decades that have elapsed since 1914, Dr. Kelly has been present to see the changes wrought by time, and through his continued efforts and interest in the Medical College of Georgia many of the exigencies have been met. Through the years, serving both in the classroom and as a medical college and hospital administrator, he never once relinquished the claim that a general hospital should be an integrated part of the medical college. It was only after his dreams of many years had reached fruition that he stepped down from the presidency of the Medical College of Georgia and turned the reins over to his successor, Edgar R. Pund.

Others, who through the years shared in the struggle and its eventual victory, must be mentioned in order that the picture may have true perspective. They were V. P. Sydenstricker, L. Palmer Holmes, and Peter B. Wright, the consultants referred to in the following article. From their respective vantage points, each contributed generously of his time and effort to accomplish what we now know as a reality, i.e., the Eugene Talmadge Memorial Hospital, a general hospital whose purpose is to serve the entire state of Georgia, and the teaching instrument for the Medical College of Georgia. Believing that this hospital would be a boon to the citizens of Georgia, as well

as to the Medical College of Georgia, these three doctors never passed up an opportunity to present their beliefs to Governor Herman Talmadge. Their shared ambition was that medical training and medical facilities in Georgia should be second to none.

Governor Talmadge generously gave his approval to their pleas; construction of the hospital was begun under the auspices of the State Department of Health, with the able support of Lee Rogers, Chairman. In the winter of 1954 the buildings and grounds were turned over to the State of Georgia Building Authority. Plans and policies gradually evolved during the period of construction. The policies developed from numerous meetings of a committee representing members of the Board of Health, the Board of Regents, The Medical Association of Georgia, and The Administration of the Medical College of Georgia. Valuable services were rendered by the members of the Building Authority under the chairmanship of Mr. B. E. Thrasher, Jr., and the office of the Attorney General, Mr. Eugene Cook. Governor Herman Talmadge made available sufficient funds to initiate the expansion of the faculty of the Medical College to permit an increase in enrollment from 76 to 100 students in each class. Chancellor Harmon Caldwell and the Board of Regents, under the chairmanship of Mr. Robert Arnold, later agreed to accept the Eugene Talmadge Memorial Hospital as an integrated unit of the Medical College of Georgia, and they provided funds for the construction of a new administration building and for additional annexes to the Dugas and Murphey Buildings.

With the dedication of the Eugene Talmadge Memorial Hospital on March 15, 1956, Governor Marvin Griffin presented this entire unit to the Medical College of Georgia, of the University System. At that time, the integration of the Medical College of Georgia and the Eugene Talmadge Memorial Hospital became a reality, thus bringing to fruition the dreams of Lombard Kelly and his confreres.

Dr. Pund is President of the Medical College of Georgia.

Evolution of the Talmadge Memorial

G. LOMBARD KELLY, M.D., Augusta, Ga.

NOT MANY OF US remember the old Augusta City Hospital, the Lamar Hospital for Negroes on Gwinnett Street, or the contagious disease hospital, ill-famed at the turn of the century as the "pest-house" for quarantine of patients with smallpox. Not one of these remains. When the Medical College was moved to its present campus, the old building on Telfair Street reverted to the Trustees of the Academy of Richmond County and was then used by the high school as a technical building; the old hospital became a dormitory for boarding students. Later the hospital building was condemned, and the salvaged brick became the wall that now surrounds the area. The small structure that once housed the horse-drawn ambulance still stands, although in poor condition. Before the Academy was moved to Walton Way, it served as a garage for the Model "T" Ford of the principal.

All of this was before the renaissance of medical education in the United States. Responsible for this renaissance was a Scottish immigrant who belied the reputation of his countrymen by giving away millions of dollars. It was the Carnegie Institute for the Advancement of Teaching that deputized Abraham Flexner to visit and thoroughly inspect every one of the approximately 150 medical schools (and alleged medical schools) in this country and Canada. This assignment was carried out with extreme zeal, and in 1910 there burst upon an unsuspecting educational world his publication which in less than three decades reversed the direction of the pilgrimages of physicians for postgraduate study—from Europe to America. The title of this publication was "Medical Education in the United States and Canada."

The less said of Flexner's caustic comments about the old college on Telfair Street and most of the other medical schools in the country the better. Suffice it to say that in the evolution of all medical centers this report was the greatest stimulus ever toward their eventual development.

First of all, admission requirements were raised—to a high school diploma, to one year of college, to two years of college, and in many instances after a decade or two, to three or even to four years of college work, with certain courses required. No longer

could the boy with a modest purse and a proud ambition drop the plough handles and get cheated into a mockery of medical training.

The immediate result was a drastic decrease in the enrollments of all of the poorer schools, about half of which, when told to put up or shut up, chose the latter alternative. The Medical College of Georgia was among those that put up. The present campus was leased, the old Tuttle-Newton Home for orphans was remodeled into an academic building, and the citizens of Augusta voted bonds for the construction of the University Hospital. Within four years after the devastating Flexner report, classes were being held in the present Newton Building, with full-time pre-clinical teachers and farseeing Dean William H. Doughty closely supervising instruction in the clinical years.

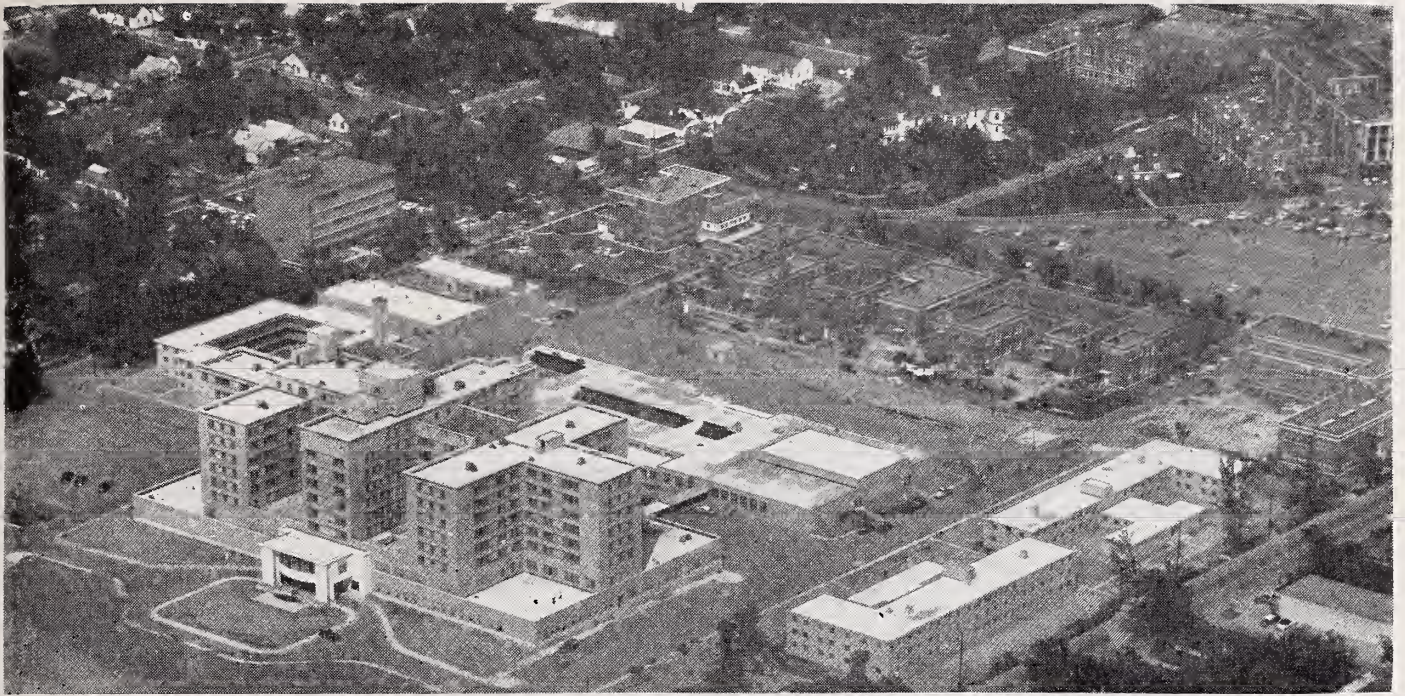
The class that matriculated in 1914 had 21 students. Five of these graduated. One transferred to another medical college and graduated there; another transferred into the school and increased the graduating class to six.

This was the nadir. Thereafter classes increased in size and in percentage of graduates. Dean Doughty obtained grants from the Rockefeller and Carnegie Foundations and inaugurated a school of public health. The first full-time clinical teacher was employed: Joseph Akerman, in obstetrics. A few years later, in 1922, full-time teachers of medicine and surgery were added. These were V. P. Sydenstricker and Ralph H. Chaney.

The size of entering classes grew from decade to decade. During the lean years of the thirties there was ample clinical material on the wards, in the outpatient department, and in domiciliary medicine, which had been started in 1925 to give senior students experience with patients in their homes. With the addition of the Dugas and Murphey Buildings the maximum number of first-year students grew from 36 to 48. Finally, after annexes were added to the Newton, Dugas, and Murphey Buildings, the 50 per cent increase to 76 materialized as the Second World War began.

At this stage in the development of the college a decisive step was taken to increase the quantity and quality of clinical cases. The administrator of the college would not agree to the increase in the enrollment unless some means was found to bring about the

Dr. Kelly is President Emeritus of the Medical College of Georgia.



essential increase. The Governor of Georgia, the Honorable Eugene Talmadge, made the first allotment to the Board of Regents for this purpose. The amount was \$50,000 per annum, and it provided 40 patients from the state at large at \$4.00 a day (all beds not being occupied every day in the year, which would have required \$58,400).

The principal purpose of this Medical State-Aid Program was to break the ice, so to speak, for the eventual construction of a state general hospital. All medical state-aid patients were certified by the county welfare departments, and in this manner a means was found of caring for medically indigent persons. The number of beds was entirely inadequate, of course, and the natural answer was a state hospital affiliated with the Medical College of Georgia.

While these growing-pains were in progress many of the clinical departments were put on a full-time basis in the so-called geographical full-time pattern. As stated above, obstetrics, medicine, and surgery led this program in 1922, followed by pediatrics in 1925. Later came gynecology, psychiatry, anesthesiology, neurosurgery, tuberculosis, urology, orthopedic surgery, and plastic surgery.

It was soon evident, with 76 students in a class, that even with the Medical State-Aid Program, the clinical material was inadequate. With the prosperity of wartime and during following years, fewer patients attended the outpatient department or made demands on domiciliary medicine. Ward patients became fewer not only for the same reason, but because of a growing unwillingness of the City Council of Augusta to continue to foot the bill of a teaching hospital for a state institution. Relations became more and more

tense. The need for a large state hospital became urgent.

Fortunately this crying need was made clear at an opportune time to one who could do something about it. Medical College consultants at Battey State Hospital had frequent conferences with the administrators of the State Health Department, and eventually members of these two groups brought the matter of a state general hospital to the attention of Governor Herman Talmadge. The Governor was very desirous of having larger classes admitted to the Medical College of Georgia, as he felt there was an urgent need for more physicians in rural areas. He therefore not only approved the construction of a large state teaching hospital, but also provided the funds for student loans according to the Mississippi Plan, to be repaid by practice in small localities for a period of years.

The appointment of a firm of architects, the selection of a hospital consultant to assist them, and the employment of a superintendent on the job from the beginning of construction are all matters of record. The hospital has been completed and now it is being equipped and staffed. By early spring it was expected that the first patients would be admitted.

The evolution of the Talmadge Memorial Hospital was motivated and consummated by the changes in medical education initiated by the epoch-making Flexner Report of 1910 and backed by the full support of the Council on Medical Education and Hospitals of the American Medical Association and the Association of American Medical Colleges.

The construction and the operation of this teaching hospital was a *sine qua non* for the continued presence of the Medical College of Georgia in Augusta. The exigency was self-evident; the need was met.

Vital Statistics Concerning the Hospital

RUFUS F. PAYNE, M.D., Augusta, Ga.

THE LATE GOVERNOR Eugene Talmadge was the first chief executive of the State to recognize the need for additional clinical material for teaching by making an appropriation for the admission of State-Aid patients to the University Hospital.

The concept of the Medical College as the key-stone of a medical center was advocated by G. Lombard Kelly in the early 1930's and was adopted as a part of the State Plan for Hospital Construction under the Hill-Burton Program. It was not put into effect until 1949 when Governor Herman Talmadge approved the program for the construction of the hospital by the State Hospital Authority, and the necessary planning began with the selection of architects and the medical consultant.

After consultation with various Public Health officials and the president of the Medical College of Georgia, detailed plans were started; these were completed late in 1952 and submitted for bids in early 1953. Georgia was most fortunate in securing the services of Herman Smith as medical consultant and Gregson and Ellis as architects. This team planned and supervised the construction of this modern and efficient hospital at a most reasonable cost. Contract was let to the George A. Fuller Company for the building contract, to the American Sterilizer Company for that part of the construction, and to the S.

and H. X-Ray Company for the X-ray equipment in March of 1953, and construction was started in May of 1953. The building was accepted by the Hospital Authority on December 15th, 1955, and is in the process of being equipped for occupancy and the acceptance of patients in April or May of 1956. The completed construction costs and architects' fees amount to approximately \$10,500,000 and the equipment will cost approximately \$1,750,000 additional or a total cost of \$12,250,000.

The buildings, when equipped, will have a bed capacity of 800, and will house approximately 300 nurses and 110 internes and residents. There is also a rehabilitation unit which will care for an additional 40 patients.

While there is no strict number of beds allocated except as necessity requires the separation of different conditions, there are 30 beds for obstetrics; this is a self-contained unit on the ninth floor with delivery rooms, nursery, and patient area. There are a premature nursery of 20 beds on the eighth floor and approximately 70 additional beds for pediatric care. One nursing unit on the eighth floor has been tentatively allocated to gynecology.

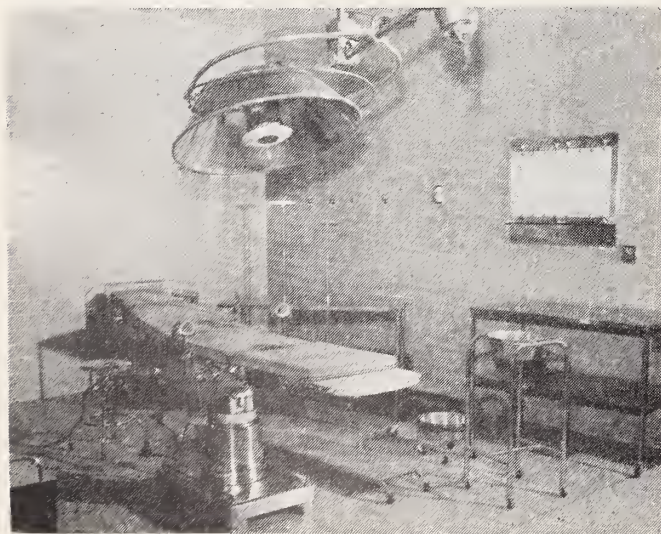
The seventh floor, which contains 128 beds, has been allocated to orthopedic surgery and/or poliomyelitis. It is assumed that, during the periods when there are great demands upon the hospital for beds for poliomyelitis, the number of orthopedic patients will be more limited, and as the need for poliomyelitis beds decreases there can be an increase in the number of orthopedic beds, particularly for crippled children.

The fifth and sixth floors, which contain 256 beds, have been set aside for medicine, with 64 of these beds being separated as a contagious disease unit which will be primarily for tuberculosis.

The fourth floor, which contains 128 beds, will be used entirely for general surgery and those surgical specialties which are not allocated to the other wings.

Third floor contains a 64-bed psychiatric unit, and an additional 64 beds will be used for medical neurology and for neuro-surgery since facilities for this type of patient will be concentrated in this area.

The hospital is dedicated to three aims, all of which are interrelated. The first of these is in the field of medical education. This hospital, with the



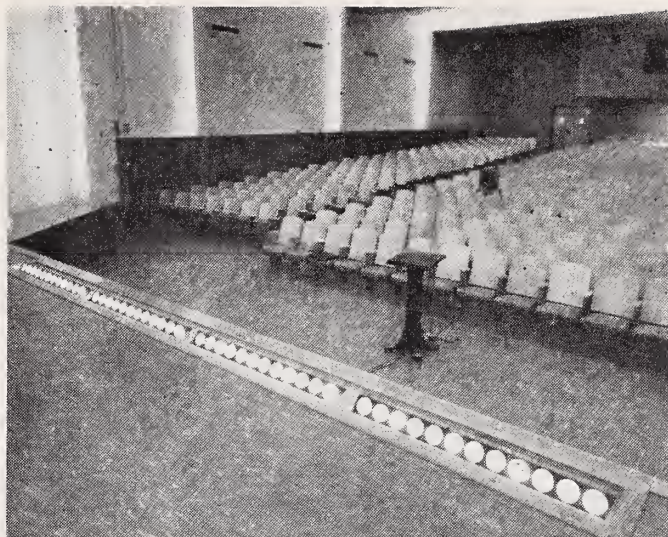
One of 12 operating rooms.

Dr. Payne is Superintendent of the hospital and Dean of Postgraduate Medical Education.

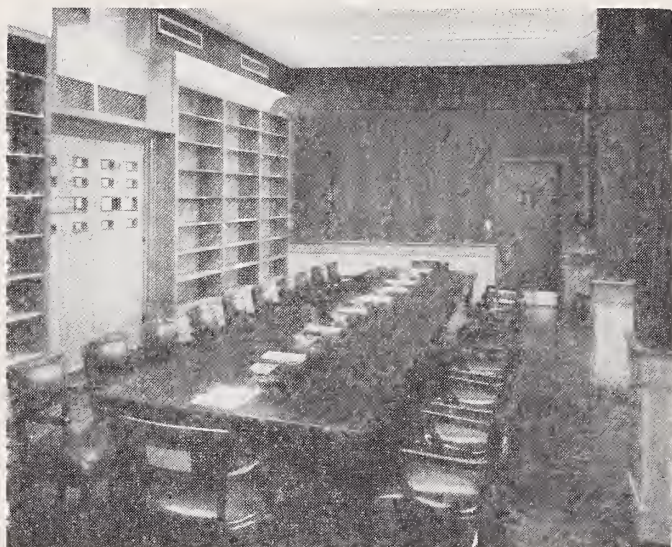
concurrent enlargement of the other facilities of the Medical College of Georgia, makes possible the increase of each first year class to 100 students per year. The number of patients with the variety of diseases and conditions which they represent makes possible a clinical experience second to none in the rest of the nation. The provision for a full-time faculty in clinical as well as pre-clinical subjects, coupled with laboratory and other facilities, offers the opportunity to double the number of places for physicians desiring advanced clinical training before entering practice in Georgia. The integration of the resident training program in this hospital with the other hospitals in Augusta and some additional hospitals in the State means that Georgia does not have to depend primarily upon the facilities in other cities and states for the training of physicians in the clinical specialties. This training is made possible only by reason of the fact that adequate facilities have been included in the hospital for classrooms, laboratories, and advanced teaching aids such as closed circuit color television which will make it possible, when completed, for students and physicians in all parts of the hospital to observe clinical demonstrations, surgical techniques, and autopsies; and even microscopic demonstrations are possible.

The second aim of the hospital is to promote clinical research. Especially worthy of mention are the laboratories and the research programs in the field of heart and vascular disease, in the study of heart and lung function, in diseases of the blood, in malignant diseases, in newer surgical techniques, in endocrine disorders, in infectious diseases, and most recently in the treatment and rehabilitation of patients with respiratory paralysis due to poliomyelitis. There are facilities provided for the use of radioactive substances in research as well as unusual laboratory and X-ray equipment for clinical investigation. As the hospital expands its faculty, there will undoubtedly develop a larger and more varied research program. It is hoped that eventually there will be an expansion of the clinical research laboratories which should be a part of each medical center. While the general laboratory facilities are unexcelled, there are special laboratory facilities on the various floors. Clinical investigation requires more extensive facilities than are now present. Laboratories for clinical investigation as a part of resident training programs are essential in a medical center.

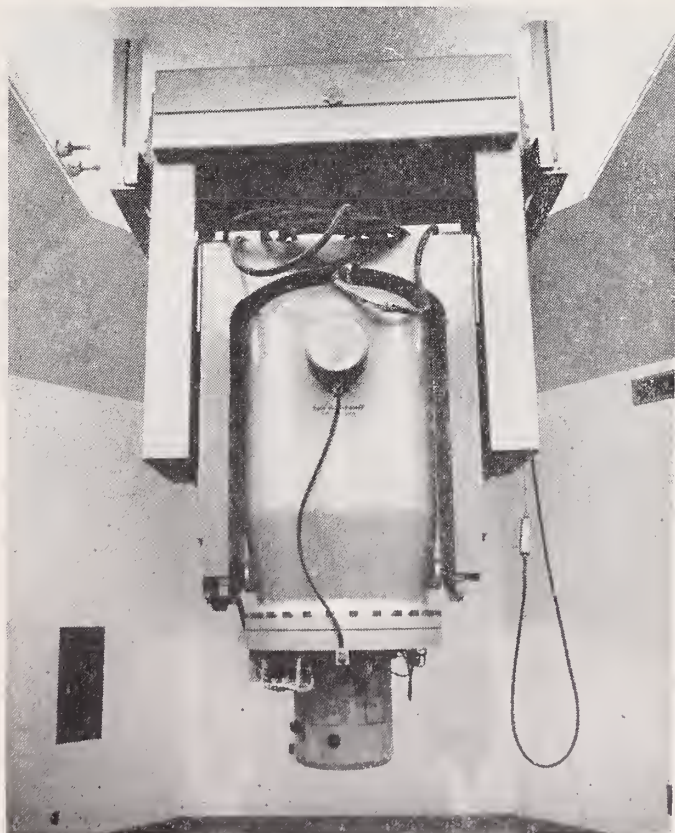
The third aim of the hospital is to furnish services to the people of Georgia in the manner that will be of the greatest benefit directly as well as indirectly through research and education. The primary aim has always been to supplement but never to compete with the services offered in the local communities. It is expected that the majority of the patients



Auditorium



Conference Room



2,000,000 X-ray Unit

will always consist of persons with insufficient financial means to take care of their medical problems who live in a community which is unable to furnish the needed care. This was the reason that the hospital was designed with more than the usual amount of space and equipment for the diagnosis and treatment of unusual problems, such as burns, malignant diseases, crippled children, early mental disease, brain tumors, eye conditions requiring surgery, prematurity, and other medical and surgical diseases requiring superior laboratory, X-ray, and surgical equipment. One example is the supervoltage X-ray therapy unit for the treatment of malignant diseases. At the present time, this is the only unit of this size and type in the Southeastern United States that is available to the civilian population.

In addition to the persons who are unable to pay

anything toward their medical care, these same services will be available to persons who can pay in part for such services but who will not be able to completely finance their medical care problems. These same services will also be available to those persons who can pay in full for their medical care but who do not have access to these highly specialized services in their own communities. To insure that such services will be available to all citizens of Georgia on a fair and equitable basis, the hospital will require that all patients be referred by either the family physician or by some agency responsible for their medical care.

Cooperation among the state, the local community, and the practicing physician to meet the problems in medical education, research, and medical care will provide a powerful demonstration of the progressive and constructive forces at work in Georgia.

Admission Policies

ALL PATIENTS MUST BE referred by a physician, in writing, unless the condition of the patient warrants emergency admission in which case a telephone call to the Admission Office will suffice. It will be appreciated if the referring physician will also supply a record of the history, physical examination, and past treatment together with his presumptive diagnosis.

Types of Cases Desired

The Eugene Talmadge Memorial Hospital is the teaching unit for the Medical College of Georgia. Emphasis is placed upon the acceptance of patients for teaching purposes who provide problems in diagnosis and treatment. The hospital cannot possibly meet the needs of all problem cases in Georgia. It is not meant to compete with other hospitals nor does the faculty of the Medical College intend to compete with private practitioners. The referring physician should therefore send only patients whose problems cannot be met at home, either by reason of lack of facilities or of funds. The hospital will function as an integral part of the Medical College of Georgia and, under the control of the faculty, will act as an agency to supplement local facilities for the benefit of all persons in the state.

Financial Policies

The Board of Regents has adopted a policy whereby the hospital administrators are instructed to have each patient pay toward his hospital care whatever amount is reasonable and just. Charges for hospital services will be rendered to all persons, regardless of their ability to pay, and will be based on an all-inclusive rate of \$25.00 for the first day and \$15.00

for each day thereafter. In those cases where outpatient services are rendered, charges will be based on the type of service rendered, but in all cases there will be an all-inclusive rate which will not exceed the hospital per diem rate.

To assist in making the decision as to what proportion of hospital charges each patient can and should pay, the referring physician is asked to give an opinion as to the amount that his patient could reasonably be expected to pay within the next 12 months without seriously interfering with the necessities of life. The hospital reserves the right to make whatever form of investigation and credit rating determination that it may deem necessary.

The physician is also requested to give an opinion as to whether the patient should pay a professional fee. In those cases where it is determined that the patient is able to pay a professional fee, the charge will be based on the standard fee schedule adopted by the Medical Association of Georgia; the patient will be billed by the staff physician who was responsible for his care. The patient will be instructed to pay such fees to the research fund at the Medical College of Georgia. A patient will not be charged a professional fee unless his hospital bill is being paid in full.

Assignment of Patients to Physicians

Whenever possible, the staff of the hospital will respect the wishes of the referring physician in assigning patients. The staff, however, reserves the right to assign patients to such services and attending physicians as may best meet the needs of the

patient. There are no private rooms in the hospital except for isolation; consequently there can be no preferential assignment on the basis of ability to pay.

Blood Requirements for Patients

It is necessary that some provision be made whereby blood can be furnished if necessary. The hospital is necessarily limited in the amount of blood it can supply, since voluntary donations from the Augusta area are usually made to the local University Hospital.

The patient, or his local community, must be responsible for furnishing whatever blood is needed, and the patient must make the necessary arrangements for his family and friends to come to the Eugene Talmadge Memorial Hospital or to go to the nearest qualified hospital or clinic to have blood drawn and processed. The hospital will accept blood, if it is properly drawn and shipped, from any clinic or hospital. In the case where the patient cannot furnish blood through such means, it will be necessary for the patient or the county to pay a donor's fee for the amount of blood required.

Instructions for the Patient

Patients should be instructed to bring to the hospital only personal toilet articles such as combs, brushes, toothbrushes, etc. The hospital will furnish standard cotton pajamas and gowns according to the patient's needs, and will also provide bathrobes and slippers. Patients may bring their own pajamas and gowns with the understanding that they will be responsible for having them laundered. Since all rooms are either two-bed rooms or four-bed rooms, patients will not be allowed to bring radios or television sets unless the radio has a pillow-type speaker or headphones. Television and radio sets will be available in the Day Rooms and in the respirator areas.

The referring physician will be informed by letter of the diagnosis, physical findings, and progress during the patient's residence in the hospital. The physician may secure additional interim reports at any time upon request. The Talmadge Hospital staff members feel very keenly the obligation and responsibility which they have for ethical relations with the physicians in Georgia. It is intended that the medical students will never have the opportunity of witnessing anything but the highest ethical standards attainable in our relations with other physicians. To this end the staff is instructed to return every patient to his referring physician with a full report of the findings.

Special Nurses

The hospital will not be able to furnish special nurses for 24-hour duty; but it is its responsibility to furnish complete nursing care to the patient. This will be done in a manner that is in the best interests of the patient and the hospital. Extremely ill patients

and patients who are terminally ill may have their relatives come to stay with them, and every effort will be made to see that these patients are in a two-bed room. Whenever possible, patients who are in a critical condition will be isolated from other patients. Adult members of the family will be welcome to come and stay with these patients, and the hospital will furnish them meal tickets for use in the cafeteria. Meal tickets may be purchased from the cafeteria in those instances in which it is felt that the patient can be benefitted by having some member of the family to assist in their care. In those cases where a member of the family is either a practical or registered nurse and wishes to care for the patient, this will be permissible if, in the opinion of the medical staff, it is essential to the patient's care, and if the nurse will place herself under the supervision of the nursing staff of the hospital and will carry out hospital instructions.

Visiting Hours

Critically ill patients may have a limited number of friends or relatives without regard to time except that the patient's welfare is the prime consideration, and the hospital reserves the right to limit visitors as the condition of each patient may dictate.

There will be no visiting by children under 12 years of age in the Pediatric Section. The number of visitors in the Obstetrical Section will be sharply limited. In general, there will be no visiting hours during the mornings, and, as a rule, patients will be allowed only two visitors at a time.

General Policies

The hospital will provide a safe for the protection of valuables and each patient must sign a statement that he takes the responsibility for whatever valuables he elects to keep on his person.

Permission for treatment, particularly surgical procedures, must be obtained from the parent or guardian of all minor children and from the guardian or next of kin in the case of persons temporarily or permanently mentally incompetent.

An effort will be made to secure autopsies on all patients who die in the hospital, and embalming service will be furnished by the hospital at no charge. Since many of the patients in the hospital will be from distant points in Georgia, it is felt that this service should be rendered by the hospital; since it constitutes such a small portion of the mortician's fee, it will probably have no influence on the final bill. The hospital will frequently call on the referring physician, if no member of the family who can legally sign an autopsy permit is present, and ask his assistance in securing from the family permission for the autopsy. Telegrams will be adequate for the purpose.



ACHROMYCIN*

Tetracycline Lederle

in the treatment of

respiratory infections


January and his associates¹ have written on the use of tetracycline (ACHROMYCIN) to treat 118 patients having various infections, most of them respiratory, including acute pharyngitis and tonsillitis, otitis media, sinusitis, acute and chronic bronchitis, asthmatic bronchitis, bronchiectasis, bronchial pneumonia, and lobar pneumonia. Response was judged good or satisfactory in more than 84% of the total cases.

Each month there are more and more reports like this in the literature, documenting the great worth and versatility of ACHROMYCIN. This antibiotic is unsurpassed in range of effectiveness. It provides rapid penetration, prompt control. Side effects, if any, are usually negligible.

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ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Attacks the infection—defends the patient—hastens normal recovery. For severe or prolonged illness. Stress formula as suggested by the National Research Council. Offered in Capsules of 250 mg. and in an Oral Suspension, 125 mg. per 5 cc. teaspoonful.

 For more rapid and complete absorption. Offered only by Lederle!

¹January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.



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Talmadge Memorial Hospital

IT IS WITH SINCERE PLEASURE that the *Journal of the Medical Association of Georgia* salutes the opening of the new Talmadge Memorial Hospital in Augusta. This new teaching facility for the Medical College of Georgia should provide a much needed area for expansion and improvement of the facilities already there. Even though there have been and remain basic differences of opinion between the hospital administration and the Medical Association of Georgia concerning certain operational aspects of the new hospital, it is hoped that with time some mutually satisfactory solution may be worked out that can meet with the approval of all concerned. This issue of the *Journal* is devoted not to controversial items but to a description of the new hospital, its facilities, its admission policies, and other factual data of interest. We are grateful for the cooperation shown by the officials of the Medical College of Georgia in providing us with the articles featured in this issue of the *Journal*.

The Reader's Dilemma

THE QUALITY OF MEDICAL WRITING has reached the proportions of a gargantuan giant poised to devour the most enthusiastic reader or conscientious scientist. Either many authors of medical subjects have never learned the art of writing or perhaps the desire to get into print is greater than the subject matter warrants. To substantiate this charge all that is necessary is a review of current medical literature. If these remarks were taken seriously, perhaps much of the data presented in the past decade would have been better left unpublished. However, if the report is of such importance that publication is absolutely essential, the reader should be spared poor composition and grammar. And above all else, the idea that length is the measure of importance of a medical paper should be discarded in favor of brevity and quality. One needs only to read a fragment of the pulp which crosses his desk each day to realize that something must be done about this great accumulation of medical literature, much of which is needless reporting.

Although organized in 1940, the American Medical Writers Association has since 1952 been active in bringing to the attention of American scientists the necessity for clarity and brevity in medical writing. Available to most physicians is membership in the

organization and the subscription to its publications. However, available to all and especially useful to the neophyte medical author, for 25 cents each, are the *Symposia on Medical Writing*, which are a compilation of the papers read at the American Medical Writers Association annual meetings since 1952. From the headquarters at 209 WCU Building in Quincy, Illinois, the interested author can obtain these *Symposia* as well as other helpful material useful in the preparation of medical manuscripts.

Many things have been said by experienced medical authors by way of advice to the would-be medical writer but none more succinctly than E. W. Shaw in *Science*, April 1954, when he published *The Ten Commandments For Technical Writers*. Reference to this report will be of invaluable assistance. The tenth of these commandments, "Thou Shalt Write and Rewrite Without Tiring, For Such is the Key to Improvement," is perhaps second in importance only to the question of Donald C. Collins, "Does my proposed article present new knowledge based upon adequate scientific data of proved value?" If it is true as Dr. Collins states, "It takes at least two years to prepare and write a worthwhile medical article," then adherence to this fact alone would reduce the number of published articles. The final plea of the reader is for a reduction in the linear measurement of publications and an increase in the breadth and depth of such material.

Tracheostomy — A Planned Procedure

ALL OF US, at one time or another, have said to ourselves and to each other, "We should have done a tracheostomy on that patient." The late great surgeon, Frank Lahey, was a strong proponent of the procedure of tracheostomy, and one of his favorite sayings was, "Doctor, the time to do a tracheostomy is when you are wondering about whether or not you should perform it." He emphasized again and again that unnecessary delay and procrastination in doing this operation not only cost many lives, but contribute in a major fashion to the morbidity in others.

Certainly one of the most important considerations, during an operation and in the post-operative course, is the continued and absolute maintenance of an adequate airway. Often all that is necessary to provide for it in the post-operative course is to

support the patient's chest and encourage coughing, whereby he readily rids himself of any retained secretions; however, on occasions it has been necessary to insert a suction catheter into the trachea, both to aspirate secretions and to stimulate a vigorous cough. On certain occasions it may be necessary to bronchoscope a patient to suction away blood clots and inspissated secretions. In those cases where frequent endotracheal suction and or bronchoscopy are needed, tracheostomy may well be indicated. Certainly where the hospital staff of nurses is somewhat inexperienced and the art of endotracheal intubation unfamiliar, the presence of a tracheostomy tube in place and functioning is a God-send to the patient. The most inexperienced intern or nurse can easily be taught all that is necessary to know about the introduction of a suction catheter through a tracheostomy tube into the endobronchial tree. The patient's airway is therefore insured at all times, both night and day.

Pneumonectomies were recently done on three elderly emphysematous patients for carcinoma. All of these cases represented the poorer risk category. At the end of two of these operations tracheostomy was immediately performed, and in one of the patients this procedure was done on the second post-operative day. They needed frequent tracheostomy tube suctioning, but despite their being poor risk patients the convalescences in all instances were gratifying. In two additional cases where almost total esophagectomy was performed for epidermoid carcinoma in the upper one-third of the esophagus, tracheostomy was also done. In one it was done in the immediate post-operative period, and in the other, approximately one week after operation. The convalescence of that patient who had her tracheostomy initially was quite smooth, and the patient was discharged from the hospital less than two weeks after her procedure. The convalescence of the patient receiving his tracheostomy a week following operation was more prolonged, and the patient had recurring bouts of pneumonitis, probably due to aspiration of small amounts of gastric contents which came through the nearby esophagogastrostomy stoma. It is not meant to be implied that all patients having high esophagectomies or pneumonectomies necessarily need tracheostomies; however, in those cases where

there is associated emphysema with limited respiratory reserve, it is felt that the patients who received tracheostomy as a planned part of the procedure did better because of it.

Tracheostomy in certain conditions is absolutely indicated: following a procedure where half of the mandible and an associated radical neck are done in continuity; in conditions where there is a large hematoma accumulation following thyroid surgery; where there has been a crush injury to the chest, "so called steering wheel injury"; in bullet or knife wounds of the trachea, and in many other similar situations. And for those occasional cases where classical indications do not necessarily obtain, tracheostomy often might well be done, not only as a life-saving maneuver, but also one to prevent unnecessary morbidity.

It is a relatively simple, short, and safe operative maneuver following any major surgery to place the patient on his back while still anesthetized, to elevate the shoulders and to make a three-inch mid-line longitudinal incision extending from just below the thyroid cartilage down to the sternal notch. This incision is deepened, usually utilizing Allis forceps down to the tracheal rings. The thyroid gland may or may not need to be retracted upward. Several small bleeding points which are usually encountered can be easily clamped and tied. After excising a small ellipse of two tracheal rings below the ring most proximal to the cricoid cartilage, the largest tracheostomy tube which will fit comfortably into the tracheal lumen is inserted. Following this, the umbilical cord ties which are attached to the tracheostomy tube should be tied fairly snugly about the neck with a firm knot, using at least three throws. When the tracheostomy tube is no longer necessary, and this is usually found to be the case at the end of the first post-operative week or certainly in the second, removal of the tube with application of a dry sterile dressing, with a wedge of vaselized gauze over the tracheostomy stoma, will see the spontaneous closure of this sinus within two or three days. There is a very small scar as a residuum with no discomfort. Certainly this is a small price to pay for the untold comfort and peace of mind which tracheostomy so often affords both the patient and physician in fostering an uneventful convalescence.

Attend The 106th Annual Session
of the
Medical Association of Georgia
May 13-16, 1956 — Atlanta Biltmore Hotel

Nitroglycerin

LINTON H. BISHOP, JR., M.D., Atlanta, Ga.

“BUT THERE IS A DISORDER of the breast marked with strange, peculiar symptoms, considerable for the kind of danger belonging to it, and not extremely rare which deserves to be mentioned here at length. The seat of it, and the sense of strangling and anxiety with which it is attended, may make it improperly called angina pectoris. They who are afflicted with it are seized while they are walking (more especially if it be uphill and soon after eating) with a painful and most disagreeable sensation in the breast, which seems as if it would extinguish life if it were to increase or continue, but the moment they stand still all this uneasiness vanishes.”

Hebeneden's excellent description of the transient pain of coronary insufficiency has not been improved upon, and it is the effect of nitroglycerin on this syndrome that will be discussed here.

In 1877 nitroglycerin was found to be effective in the relief of the pain of angina pectoris and today is still the surest method of treatment. Statistics show us that nitroglycerin is effective in about 90 per cent of the cases of angina. It is often so dramatically effective that patients feel it is lifesaving.

Although we prescribe it very frequently, often we are not as careful in its precise use as we should be. To be most effective, the medicine should be used early in the paroxysm. The earlier it is used the more effective is the remedy. Many of our patients refuse to take advantage of this medicine because of the severe side effects. The common dosage usually prescribed is 1/100 gr. and often this is too much. The smallest dose that is effective is the dose of choice. Nitroglycerin is now available in 1/200 and 1/400 gr. sizes, and these small doses should be tried.

Another common fear that should be dissipated is the fear of the patients that they will develop a tolerance to the medicine and that it will no longer be effective. They should be reassured that their pain will not become resistant to the effect of nitroglycerin and that as much can be taken daily as is necessary

to relieve the attacks. Fear of addiction is also groundless, but this fear causes major concern to some patients. Repeated reassurance that they will not become addicted to the medicine may be necessary.

Prophylaxis should be considered. Nitroglycerin used prophylactically to prevent pain is most effective. If one can anticipate activity which usually brings pain, the use of a tablet prior to the occurrence of pain should be strongly advised. Its use before meals can often prevent post-prandial distress, and its use before intercourse may also prevent discomfort. One patient uses it as a hunting aid, taking it when he hears a wild turkey gobble to prevent the pain that is always brought on by this excitement.

Diagnostic significance is certainly attached to the rapid relief of chest pain by nitroglycerin. This is a good and valid observation, but it must be remembered that other types of smooth muscle pain, gall-bladder, renal, and intestinal, may also be relieved by the nitrates. The mere fact that the pain is rapidly relieved by nitroglycerin does not obviate the necessity of a careful history to determine if coronary insufficiency is truly present.

Dangerous drops in blood pressure have been recorded after the use of nitroglycerin. Because of the potential blood pressure lowering effect of the medicine many of us prefer not to use it in the presence of acute myocardial infarction. If a patient has prolonged chest pain, I prefer using not nitroglycerin but a more powerful analgesic agent.

It must also be remembered that nitroglycerin is a volatile substance and that after prolonged exposure to the air the tablets lose some of their effectiveness.

Nitroglycerin is a very common and very necessary part of the armamentarium of anyone dealing with coronary heart disease, and for its use to be most effective, one must understand the therapeutic, diagnostic, and prophylactic properties of this simple, most useful chemical, trinitrotoluene.

Prepared at the request of the Committee on Professional Education
of the Georgia Heart Association.

Heart Association Clinics in Georgia

Albany Heart Clinic
Dougherty County Health Center
P. O. Box 127
Albany, Georgia

James A. Redfearn, M.D.
Chief of Clinic

Mrs. Anne Sulenski
Clinic Secretary

Athens Heart Clinic
Michael Memorial Clinic Bldg.
Athens, Georgia

Bolling DuBose, Jr., M.D.
Chief of Clinic

Mrs. H. B. Harris
Clinic Secretary

Atlanta Cardiac Clinic
Grady Memorial Hospital
P. O. Box 3277
Atlanta, Georgia

J. Gordon Barrow, M.D.
Chief of Clinic

Mrs. Kathryn Starr
Clinic Secretary

Augusta Heart Clinic
University Hospital
Augusta, Georgia

Calhoun Witham, M.D.
Chief of Clinic

Mrs. Avery J. Beale
Clinic Secretary

Brunswick Heart Clinic
Glynn County Health Center
Brunswick, Georgia

Haywood L. Moore
Chief of Clinic

Mrs. Frances Andrews
Clinic Secretary

Columbus Heart Clinic
City-County Hospital
Columbus, Georgia

Jack M. Hirsch, M.D.
Chief of Clinic

Mrs. Kathleen Reddick
Clinic Secretary

Giddings Memorial Heart Clinic
St. Joseph's Infirmary
272 Courtland Street, N.E.
Atlanta, Georgia

T. Sterling Claiborne, M.D.
Chief of Clinic

Mrs. Miriam Minus
Clinic Secretary

Jesup Heart Clinic
Wayne County Health Center
Jesup, Georgia

Mrs. Alice P. Latham
Clinic Secretary

LaGrange Heart Clinic
City Hospital
LaGrange, Georgia

William B. Fackler, M.D.
Chief of Clinic

Macon Heart Clinic
City Hospital
Macon, Georgia

Allan A. Cole, M.D.
Chief of Clinic

Mrs. Frank Cary
Clinic Secretary

Savannah Heart Clinic
23 E. Charlton Street
Savannah, Georgia

Jean Williams Nichols, M.D.
Chief of Clinic

Mrs. Henrietta F. Mason
Clinic Secretary

Thomasville Heart Clinic
Thomasville, Georgia

Oscar M. Mims, M.D.
Chief of Clinic

Mrs. Delores Baisden
Clinic Secretary

Waycross Heart Clinic
Ware County Health Center
Waycross Georgia

Arthur M. Knight, Jr., M.D.
Chief of Clinic

Miss Marie Carroll
Clinic Secretary



physician's bookshelf

Reviews

VIRAL HEPATITIS — CLINICAL, LABORATORY, AND PUBLIC HEALTH ASPECTS, Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C., 55 cents.

This publication deals with the aspects of viral hepatitis that concern the practicing physician and the health worker and is intended to serve as a practical guide for their use. It was prepared by the Hepatitis Investigations Unit of the Communicable Disease Center, Public Health Service, U. S. Department of Health, Education, and Welfare, Atlanta, Georgia.

The first section is a comprehensive account of known facts concerning viral hepatitis, emphasizing clinical and epidemiologic features and discussing the generally accepted methods of diagnosis, prevention and treatment. The next section describes the most useful laboratory tests for detecting liver dysfunction, explains the limitations of each and its range of applicability, and tells which tests are adaptable to use in small laboratories and in the field. The third section deals with the public health aspects of hepatitis including the role of the health department in the study of the disease and suggests methods of investigation. Appendices contain detailed information which is intended as a practical aid to health department personnel. Much of it is suggested plans which may easily be adapted to a variety of situations. Included are the procedures to be followed in an epidemic area, a plan for organization of mass inoculation clinics, and questionnaires to be used in the investigation of outbreaks.

Sterling, Dorothy and Philip, POLIO PIONEERS, Doubleday and Company, Inc., New York, 1955, 128 pp., \$7.75.

This volume, intended for children, is a well-written presentation of the contributions of numerous scientists, both past and present, toward controlling or preventing poliomyelitis. Although chief emphasis is placed upon polio and the development of the Salk Vaccine, the role of discoveries in other scientific fields is traced.

The material presented is aimed at the upper grade-school level and would be beyond the grasp of younger school-age children unless further simplified by parent or teacher. Unfortunately it is the latter group that is receiving the Salk Vaccine to the greatest extent and would perhaps benefit most from reading about polio.

T. F. Sellers, Jr., M.D.

Wolstenholme, G. E. W., O.B.E., M.A., M.B., B.Ch.; and Margaret P. Cameron, M.A., A.B.I.S. (Editors), AGEING—GENERAL ASPECT, CIBA FOUNDATION COLLOQUIA ON AGEING, Vol. 1, Little Brown and Company, Boston, 1955, 255 pp., \$6.75.

Among the things that our English cousins do particularly well is the presentation of panel discussions that are easy to read. In this volume on the fundamental problems of growing old there are 34 participants representing the British Commonwealth, Germany, France, Belgium, Switzerland, and the United States. The 10 Americans include Aub, Bean, Cowdry, and Lansing of Emory University.

It is trite to say the life span is increasing with consequent increasing numbers of old people and that the problem of the elderly concerns each doctor. Certainly in this book he will find a good beginning for his studies of the subject. Some of these short papers are a bit over this reviewer's head, but the level of interest is high. The discussions, even though these international authorities don't hesitate to express disagreement with each other, are provocative.

L. Minor Blackford, M.D.

Molooof, Louis J., PLANNING FLORIDA'S HEALTH LEADERSHIP: MEDICAL EDUCATION IN THE UNIVERSITY, Univ. of Florida Press, Gainesville, 1955, \$1.50.

In the fifth volume of this series, the author has described the way in which medical education can be integrated with the total program of the university. A detailed announcement of staff and facilities in the various divisions of the University of Florida are included. Much sound thinking and staff work already have been done by the faculty and the administrative officers. This would seem to assure the opportunity for the broad education and training of physicians and ancillary medical personnel to serve Florida's health needs. For example, the book describes how the divisions of veterinary medicine, nutrition, biology, psychology, sociology, and anthropology may play a significant role in the education of a physician.

The last chapter entitled "The University and Medical Education" outlines a plan of integration of the liberal arts and the science courses with the medical curriculum. Under their 2-4-2 plan, a method is outlined whereby the premedical student would begin to take certain medical science courses during his last two years in college. In like manner, the liberal arts courses would continue into the traditional medical school years. While this presents some administrative problems, it is a challenging approach to sound medical education.

R. Hugh Wood, M.D.

Chandler, Asa C.; **INTRODUCTION TO PARASITOLOGY**, Ninth Edition, John Wiley and Sons, New York, 1955, 799 pp., \$8.50.

This extensively revised text gives a strictly modern account of parasites, with particular reference to their nature and epidemiology, and the facts regarding their diagnosis, prevention, and control.

Chandler's classic volume retains its emphasis on the parasites of man, with ample attention directed to general, medical, and veterinary parasitology. Characteristically, the author has kept pace with increasing world interest in his subject and has shifted his emphasis according to topics now in the forefront of scientific research. The result is a page by page reappraisal of his material, within the major headings labelled Protozoa, Helminthology, and Arthropods.

Among the fully revised accounts in this edition are the discussions of resistance and immunity, leptospirosis, amebas, hemoflagellates, schistosomes, insecticides and repellants, and the African trypanosomiasis of man and animals. There is new data on the conquest of syphilis by penicillin, the end of malaria as an endemic disease in the United States and parts of Europe, Babesiidae, Toxoplasma, the physiology of helminths and immunology in helminthic infections, techniques for tapeworm infections, and invasion routes of animal ascarids.

Also among the nearly 70 individual topics either enlarged or rewritten are the section on onchocerciasis, the discussion of larvae of foreign species of filariae, and an account of the species, habits, and vector potential of various species of Simuliids to onchocerciasis and of tsetse flies to African Trypanosomiasis. These and many other details of biological and medical interest are accompanied by a drastic change in illustrations; of the 257 figures, approximately half have been improved or recast.

Dr. Chandler, professor of biology at the Rice Institute, was formerly affiliated with the Hookworm Research Laboratory and the Calcutta School of Tropical Medicine and Hygiene. His intensive studies in parasitic diseases and sanitary conditions have taken him to various parts of the world and resulted in innumerable articles and several larger works.

SURGICAL FORUM, Proceedings of the Forum Sessions, 40th Clinical Congress of the American College of Surgeons, Atlantic City, N. J., November 1954; W. B. Saunders Company, Philadelphia, 1955, 851 pp., \$10.00.

This book is a collection of papers that were read and discussed at the Surgical Forum Sessions of the American College of Surgeons in Atlantic City in November, 1954. The articles have been shortened with very few illustrations, but detailed enough for critical consumption.

It gives one a good cross section of the surgical research programs throughout the entire country. This

will not only stimulate further work and new ideas, but prevent repetition and/or neglect of a subject.

I would estimate that only about 40 per cent of the book is of practical value to the general surgeon not doing experimental work, but even for those doing only clinical surgery there are many worthwhile and valuable ideas such as work on gastric, pancreatic and liver physiology, arterial homografts, and electrolyte balance. There were 10 chapters with approximately 12 experimental papers in each chapter. The one on steroids and cancer was extremely illuminating and represented a vast field for further research. There were many points brought out in this chapter which were applicable today in modern surgery.

The chapter on anesthesia and burns was rather weak, with a few exceptions.

Each section is summarized in that particular field by an outstanding surgeon, usually a professor, who himself has markedly contributed to the subject.

Charles H. Watt, Jr., M.D.

Williamson, Paul, M.D., **OFFICE PROCEDURES**, W. B. Saunders Company, Philadelphia, 1955, 412 pp., \$12.50.

This is a book which should be a basic part of every general practitioner's library, even if that library consists otherwise only of Gray's *Anatomy*, DeLee's *Obstetrics*, Cecil's *Medicine*, and Christopher's *Minor Surgery*.

Dr. Williamson has organized, in 15 sections, the information that a general practitioner is supposed to have the day he opens his office and seldom has *in toto* on the day that he dies. Sections I through X are headed: Ear Nose and Throat, Eye, Musculoskeletal System, Gynecology, Obstetrics, Urology, Proctology, Pediatrics, Minor Surgery, and Internal Medicine; they consist of explicit instructions on techniques for practically any procedure that can be done in the office. These instructions are given succinctly, with wit and wisdom, and are accompanied by numerous illustrations which are both instructive and edifying. Section XI on Psychological Testing might have been omitted with little loss, but there is room for considerable difference of opinion in this case. Section XII on Anesthesia should have included Chloroform and Trilene and omitted Pentothal, and Section XIII on Physiotherapy has omitted Ultrasonic, but when compared to the worth of the whole volume, I feel that these criticisms are minor. Sections XIV: The Small Laboratory, and XV: Roentgenography, will be of inestimable help to anyone contemplating a rural practice.

In conclusion, this reviewer has seldom, if ever, read a technical work with such enjoyment and repeats his belief that this book will be a medical classic.

W. Lawrence Salter, M.D.

Activities of the M. A. G. Mental Health Committee

THE COMMITTEE ON MENTAL HEALTH of M.A.G. has held two meetings of the full committee and one additional meeting of each of the subcommittees. The first committee meeting was held at the Milledgeville State Hospital where Dr. Peacock gave the committee a brief picture of the present activities and operation of the State Hospital. The committee reviewed the report submitted in March 1955 and agreed that every effort should be made to support the recommendations submitted at that time, namely (1) that the legislature be encouraged to pass a model commitment law; (2) that the legislature be advised that the sexual deviant should be considered a person who is emotionally and medically ill and should be treated in the State Hospital, rather than in prison; (3) that the procedure by which a patient or his relatives "appeal" from commitment to the State Hospital be subject to question and examination by the legislature; (4) that the \$2.75 per patient per diem rate at the Milledgeville State Hospital be approved; (5) that the recommendations of the Southern Regional Educational Board for the establishment of an intensive treatment team at the State Hospital be approved; and (6) that endorsement of the State Health Department's plan for Community Health Clinics and Child Guidance Centers be given.

The committee then agreed that we wish to undertake two broad areas of activity during this year: (1) to formulate a policy statement for adoption by the Medical Association in regard to the physician's attitude toward medical care and treatment for the mentally ill; (2) to develop a program of continuing information for the members of the Medical Association relating to commitment procedures, and care and treatment of those persons suffering with mental and emotional disturbances. Two subcommittees were formed to carry out these specific functions.

The second meeting of the committee heard reports from both subcommittees and also a report on the mental health program now being carried on by the Mental Health Division of the State Health Department under the direction of Dr. Guy Rice. The committee was impressed with the careful planning and development of the Mental Health Program in the Health Department and are especially interested in the program being carried on in cooperation with the Milledgeville State Hospital in which the County Public Health nurses contact the families of all persons admitted to the State Hospital

from those counties having this program. They provide emotional support and understanding for the families during the time the patient is in the hospital and help in meeting the adjustment problems which arise when the patient returns home from the hospital.

The meeting of mental health representatives from the state medical associations in Chicago was an excellent meeting, with a well planned program and active participation on the part of all doctors attending. The activities of our Association compare favorably with those of other medical associations in that we are all acting on the fundamental belief that the responsibility for leadership in the field of mental health rests with the medical profession and requires the cooperation and guidance of psychiatrists working closely with representatives of all medical specialties to develop a broad program. The Council on Mental Health has been concerned with defining the relationship between clinical psychologists and the medical profession, and the present A.M.A. position does not appear to differ very much from the position taken in this state. The A.M.A. does, however, recommend that psychologists only be certified in their profession as to qualifications for practice, rather than that they be licensed to practice any form of healing art. I think that it would be a good idea for our association to send a copy of the present Georgia law relating to clinical psychologists to the legal section of the A.M.A. and request an opinion from the A.M.A. as to how this law compares with the present recommendations of the A.M.A.

The outstanding presentation at the Chicago meeting was made by Dr. Walter Barton of the Boston State Hospital describing the program at his hospital in which he attempts to integrate the treatment of mental illness and the program of the state hospital into the total medical community. He described an active program in which the state hospital was operated very much like any other hospital, with a visiting staff of specialists in all fields making ward rounds and teaching residents and interns. This provided education for the physicians in local communities relating to the treatment of their patients in the state hospital, and at the same time served as a stimulus to the improvement of treatment for patients in the hospital. This committee is considering this report and hopes that this thinking can be included in our recommendations for the improvement of services for the mentally ill in our state.

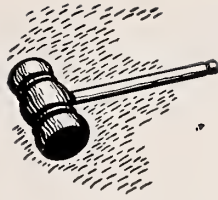
Do You Know?

Ten per cent of the public school children in the United States need mental guidance, according to the Columbia University's Department of Psychiatry following a nation-wide survey.

Three quarters of a million mentally ill and retarded

patients are now being hospitalized in this country on any given day.

The first economic cost of mental illness to the taxpayers of the nation, including pensions to veterans with psychiatric disabilities, is over one billion dollars a year.



president's page

A VERY PLEASANT PART of the work of this year as well as last year while President-elect has been the visits to some of the meetings of most of the district societies. The district society has a rather unique autonomy in our medical organization. While fixed geographically to each councilor district, the officers, the dues, the arrangements for the meetings are completely on their own. Aside from the local councilor, the officers of the State Association are there by invitation and this a very pleasing and carefree way to attend a gathering. We are very fortunate that these societies are active and they afford the closest touch with our basic units, the county or county group societies.

In this my eleventh page I wish to pay special respect to the district meetings that I have attended, the very high quality of the scientific programs, as well as the dispatch with which business had been transacted even to the election of new officers, and concluding with a social hour and banquet at which the ladies of our auxiliary are always present.

These meetings reduced to an afternoon and evening have greatly increased attendance. As I have reckoned attendance at the district meetings and knowing that all doctors cannot attend all meetings, I believe that the total attendance plus the annual convention equals the total of our state membership. With this much representation at district meetings and still more if attendance at county meetings could be counted, more voice should come up to headquarters as to basic feelings concerning medical programs and policies.

H. D. Allen, Jr.

Council of the MAG

March 17, 1956, Savannah

CHAIRMAN J. W. CHAMBERS called the meeting to order at 2:15 p.m. in the Whitmarsh Room of the General Oglethorpe Hotel. The chair was then relinquished to Vice-chairman Dillinger.

The following were present: H. Dawson Allen, Jr., Milledgeville, President; Hal M. Davison, Atlanta, President-elect; William P. Harbin, Jr., Rome, Immediate Past President; David Henry Poer, Atlanta, Secretary-Treasurer; Lee Howard, Sr., Savannah; George R. Dillinger, Thomasville; Luther H. Wolff, Columbus; J. W. Chambers, LaGrange; James M. Hicks, Brunswick, W. Bruce Schaefer, Toccoa; R. C. McGahee, Augusta, 1st Vice-president; Stephen W. Brown, Augusta, 2nd Vice-president; Thomas W. Goodwin, Augusta, Speaker of the House of Delegates; Chris J. McLoughlin, Atlanta, Chairman, Public Relations Committee; Edgar Woody, Jr., Atlanta, MAG *Journal* Editor; Mr. Milton D. Krueger, Executive Secretary; Mr. John F. Kiser, Asst. Executive Secretary; and Miss Frances Porcher, MAG *Journal* Managing Editor.

The minutes of the Executive Committee of Council meeting, December 17, 1955, were read and approved. The minutes of the Council Meeting were read and approved with the addition of Dr. Dillinger's written letter to the auditor. Minutes of the Executive Committee of Council meeting, January 19, 1956, and the Council meeting, February 5, 1956, were approved as read.

Mr. Krueger presented Mr. Harold Palmer of the deLeon Laboratories, 134 Houston Street, N. E., Atlanta, who requested permission to exhibit at the 1956 Annual Session. Mr. Palmer presented the deLeon Laboratories' charter and information about the corporation: its research program, financial status, method of sales, and stockholders. It was moved that the deLeon Laboratories be allowed to exhibit at the 1956 Annual Session.

Mr. Kiser, reporting for Legislative Committee Chairman Grady Coker, gave a resume of legislative activity for the year 1955-56. It was moved that: Council officially express its appreciation to Mr. Kiser for his efforts in behalf of the Medical Association of Georgia, and in particular for his success in bringing about the elimination of at least one cult from practice in the State of Georgia, and further that this be published as a special item in the *Journal of the Medical Association of Georgia*. This motion was passed unanimously.

Dr. Chambers gave a resume of the national legislation in regard to H.R. 7225. He discussed the testimony on this bill that he gave before the Senate Finance Committee. It was moved that the Council express its position on this measure as follows:

"The Council of the Medical Association of Georgia strongly urges the Finance Committee of the U. S. Senate to create a well-qualified Study Commission to make a thorough and objective study of all aspects of the Social Security System.

"The Council respectfully suggests that this be undertaken before Congress passes any major amendment to the Social Security Act, such as H.R. 7225 now pending in the Senate Finance Committee. H.R. 7225 represents a significant change in the social security program by

making benefits available for physical and mental ailments rather than for advanced years.

"This plan of payments for disability, in addition to being incalculable in costs, would endanger the present extensive rehabilitation programs on federal, state, municipal, and private levels, for we, as physicians, know that cash benefits contingent on continued disability are contrary to sound medical practice in the treatment and rehabilitation of disabled persons.

"The Medical Association of Georgia would urge Senate Finance Committee and, in particular, Senator Walter George, an influential committee member and strong supporter of H.R. 7225, to consider the overwhelming evidence brought out in the committee hearings that this bill is unwise and unnecessary at this time and that it should not be considered without first analyzing the entire scope of its effect on the social security system.

"As physicians who are deeply concerned with the problem of caring for disabled persons, we would urge Senator George and his colleagues to strengthen the present expanding rehabilitation program, not destroy it by paying pensions to the handicapped.

"Disabled persons need medical rehabilitation, vocational training and placement, not cash assistance."

Council unanimously approved this statement and requested that it be released to the press and proper legislators in the Congress of the United States.

Dr. Davison reported on the Annual Congress of Medical Education and Licensure held in Chicago, February 11-14, 1956. He gave a resume of the meeting and explained he has in process a survey of data on medical education policies as practiced in the United States; this will be available sometime during the year.

Dr. Poer presented a review of the actions of the Medical Association of Georgia in regard to the operational policies of the Eugene Talmadge Memorial Hospital. After discussion by members of Council, it was moved that a sub-committee of Council be appointed by the Chairman of Council to study the status of the controversy and report to Council prior to the Annual Session.

The meeting was recessed at 5:00 p.m.

March 18, 1956

THE MEETING WAS RECONVENED at 9:15 a.m., Sunday, March 18, by J. W. Chambers, Chairman. Present, in addition to those present at the Saturday meeting, was Neal F. Yeomans, Waycross.

Dr. Poer gave a report on the Association's 1956-57 objectives. He stated that emphasis would be placed on public relations projects such as auto safety, rural health, mental health, blood banks, and hospital-relations. Dr. Poer discussed the need for a third man in the Headquarters Office and also the need for more space and equipment. He also recommended that Council consider the possibility of providing more adequate representation on Council from the larger county societies.

A report of the 1956 Annual Session to be held May 13-16 at the Atlanta Biltmore Hotel was given by Mr. Krueger. It was recommended that a permanent Annual Session Committee be set up by Council to work with the chairmen of the various specialty societies.

It was moved that the report of the Constitution and By-Laws Committee be approved. That report follows these minutes.

It was voted that companies submitting policies for

approval under the Georgia Plan should bear the expense of legal review of these policies. The report of the Legal Counsel Committee was accepted and the new definition of the duties of the Medical Defense Committee in the Constitution and By-Laws was approved.

Dr. Poer presented a report of the Reserve Fund Committee of Council. The committee is considering diverting these funds for a new MAG building, if Council and the House of Delegates decide to move the Association headquarters. The committee is also investigating the lending of money to young doctors on a plan similar to that sponsored by the Sears-Roebuck Company.

The report of the Hospital-Physicians Relations Committee of Council was presented by Dr. Howard. The change in name of the committee to "Institution-Physician Relations Committee" was approved. Henry H. Tift, Macon, Sixth District Councilor, was named to replace Lee Howard, Sr., as the representative from Council on the committee and as chairman of the committee. Dr. Howard was made an *ex-officio* member of the committee.

Council voted to approve the questionnaires submitted by the Hospital-Physicians Relations Committee.

Next item of business was the report on plans for a Southeastern State Medical Journal Conference by Edgar Woody, Jr., Editor of the *Journal*. Dr. Woody described in detail the tentative program for this conference. Council approved the plans as outlined and the request for \$500.00 for the conference, subject to the approval of the Finance Committee.

The formation of a committee to study MAG policy on Association lectureships was approved. Following this action, it was voted to accept the Euen lectureship, subject to the approval of the special committee.

It was moved that recommendations for appointments to State commissions be made by the Executive Committee.

It was recommended that the Association send the MAG Legal Counsel and a member of the Headquarters Office staff to a meeting, sponsored by the AMA to be held in Chicago, April 19-20, of attorneys representing state and county medical societies.

It was moved that a libel-and-slander insurance policy be procured if funds are available.

It was decided that the MAG should cooperate with AMA by polling the membership on their views concerning inclusion under social security and also by publicizing the MAG's opposition to H.R. 7225.

Recommendations for additional office equipment were referred to the Finance Committee.

Council approved the authorization for Dr. T. F. Sellers to represent the Association at the Rural Health Conference in Portland, Oregon, and in this connection authorized expenditure of funds to cover his hotel expenses and meals.

It was moved that copies of the resume of the Eugene Talmadge Memorial Hospital controversy be sent to Richmond County Medical Society for consideration and approval before it is submitted to the House of Delegates.

Dr. Woody raised the point of the *Journal's* acceptance of special pages in the *Journal* to be devoted to specialty society activity or committee activities. This matter was referred to the Publications Committee.

Council voted to extend an invitation to the Ameri-

can Diabetes Association to hold its annual meeting in Atlanta in 1958.

Dr. Yeomans discussed a problem in connection with the official uniform of practical nurses. This matter was referred to the Hospital Committee for consideration.

It was voted that the next Council meeting would be held in Atlanta at 6:30 p.m., May 12, 1956.

Council passed a motion thanking Dr. and Mrs. Howard of Savannah for their hospitality during the Council meeting.

There being no further business, the meeting was adjourned.

Mental Health Committee

December 11, 1955, Macon

The second meeting of the whole Committee on Mental Health of the M.A.G. was called to order at 1:45 p.m., Sunday, December 11, in the Mirror Room of the Dempsey Hotel by Chairman Rives Chalmers, Atlanta.

Members present were: Dr. Chalmers, George H. Alexander, Forsyth; T. J. Vansant, Marietta; J. T. Scoggins, Commerce; Arthur M. Knight, Jr., Waycross; Paul Schroeder, Atlanta; J. R. Shannon Mays, Macon, and consultants Guy V. Rice, Atlanta, and T. G. Peacock, Milledgeville.

Also present were Dr. and Mrs. R. M. Paty of Covington; Mr. W. C. Rhodes of the State Health Department; Miss Florence Beasley, Nurses Consultant, State Health Department; and Mr. John F. Kiser of the M.A.G. Headquarters Office.

The first item of business was a presentation on the part of the State Health Department explaining their mental health program. Guy V. Rice, head of the Division of Health Conservation Services of the State Health Department, introduced the subject and presented the general background. Then Mr. W. C. Rhodes, Acting Director of the Section on Mental Hygiene, and Miss Florence Beasley, Nurse Consultant to the Section on Mental Hygiene, discussed the program in detail.

Mr. Rhodes explained that his department work with a number of other divisions of the State Health Department in promoting mental health programs. He mentioned activity now being conducted with the health education department, the school health department, industrial health, TB division, and maternal and child health. He then discussed the specific activity directly under the mental hygiene division and the operation of the four mental hygiene clinics in Georgia (in Atlanta, Macon, Savannah, and Columbus); he and Miss Beasley discussed in detail the Public Health Nurse program in connection with the families of patients at Milledgeville State Hospital.

Following Mr. Rhodes' excellent presentation, the committee recommended that a special article outlining these activities be published in the *Journal*.

The minutes of the August 7 meeting were read and discussed.

The next item of business was a report of the AMA meeting of State Association Mental Health Committee Chairmen by Dr. Chalmers. He discussed the problems of narcotics, the Joint Commission on Mental Health, and the psychiatrist's relationship with psychologists. It was recommended that the Georgia Law licensing psychologists be referred to the AMA Legal Department for its view.

Dr. Knight, as chairman, gave the report of the Subcommittee on Mental Health Information.

The committee voted to recommend that a Mental Health Page be included in the *Journal* similar to the Heart Page and Cancer Page. It was agreed that the subjects would be of everyday interest to the practicing physician, and that the chairman would assign the subjects to the various members.

The committee discussed a proposal to send out postcards with telegraphic messages on Mental Health subjects similar to a project of the Georgia Division of the American Cancer Society. It was decided that the committee would support this project with help from other groups.

The committee voted to take responsibility for providing speakers on mental health at county society and district medical society meetings in the state. It was voted to consult the Georgia Psychiatric Society and other medical groups that might cooperate in such project.

The next item of business was the report of a meeting held December 11 of the Subcommittee on Policy by Chairman J. R. Shannon Mays. He discussed the proposals that were made at the meeting, but said that no definite statement had been formulated and the subcommittee would meet again prior to the next meeting of the full committee.

Dr. Mays pointed out that the subcommittee was concerned about the attitude of the general public in regard to mental illness and patients suffering from mental illness. The subcommittee observed that this attitude must be changed if mental patients are ever to receive the same quality of care that is given other sick persons. A rough draft of a statement of policy that will be polished and eventually presented to the entire Association through the House of Delegates was formulated.

The next item of business was the report of the Woman's Auxiliary by Mrs. Paty, who stated that the Auxiliary was also working on a speakers' bureau program and wanted the cooperation of the M.A.G. The committee voted to support Mrs. Paty's program in every way.

Plans for the next meeting of the committee were discussed, and it was decided that the full committee would not set a definite meeting time, but that a rough draft of the report of the committee would be circulated among the members for their approval. Dr. Knight was assigned to contact the Georgia Bar Association in regard to a proposal to publish a booklet on commitment laws in Georgia for distribution among doctors and others.

Dr. Chalmers reported on a conference with Governor Griffin in regard to a proposal to set up screening centers for the Milledgeville State Hospital and other large cities over the State.

There being no further business, the meeting was adjourned.

Report of the Constitution and By-Laws Committee

CONSTITUTION AND BY-LAWS

Proposed Revision

The following changes in the MAG Constitution were read and approved for the first time on May 3, 1955. These proposed changes will be read for a second time at the 106th Annual Session, May 13-16, 1956, at the Atlanta Biltmore Hotel, Atlanta, Georgia.

Now Reads:

CONSTITUTION ARTICLE I.

Name of the Association

The name of this organization is The Medical Association of Georgia.

Will Read:

CONSTITUTION ARTICLE I.

Name of the Association

The name of this organization is The Medical Association of Georgia. It is an association of its component county medical societies.

Now Reads:

ARTICLE II.

Purposes of the Association

The purposes of the Association shall be to advance the science of medicine; to promote the interests and uphold the honor of the profession of medicine; to acquire, utilize and disseminate information relative to all diseases and degenerative processes affecting mankind to the end that the people of Georgia may have the most adequate medical care possible; to promote public health, and to foster cordial relations between the members of the medical profession and the general public.

Will Read:

ARTICLE II.

Purposes of the Association

The purposes of the Association are to promote the science and art of medicine and the betterment of public health.

Now Reads:

ARTICLE III.

Component Societies

Component societies are those county medical societies which hold charters from the Association or which may hereafter be organized and chartered by the House of Delegates of the Association.

Will Read:

ARTICLE III.

Component Societies

Component societies are those county medical societies which hold charters from this Association or which may hereafter be organized and chartered by the House of Delegates of this Association which will form the Medical Association of Georgia.

Now Reads:

ARTICLE IV.

Composition of the Association

Sec. 1. The Association is composed of members and delegates.

Sec. 2. Members. The members of the Association are the members of the component county medical societies.

Sec. 3. Delegates. Delegates are those members elected in accordance with this Constitution and By-Laws to represent their component county medical societies in the House of Delegates of the Association.

Will Read:

ARTICLE IV.

Membership

SEC. 1. MEMBERS. The members of the Association are the members of the component county medical societies. The Association is composed of Active, Service, Associate and Honorary members as provided for in the By-Laws. Other types of membership may be provided for in the By-Laws.

SEC. 2. TENURE OF MEMBERSHIP. A member shall retain his membership as long as he complies with the provisions of the Constitution and By-Laws of this Association and with the Principles of Medical Ethics of the American Medical Association.

Now Reads:

ARTICLE V.

House of Delegates

Sec. 1. Powers. The legislative body of the Association is the House of Delegates and it shall transact all business of the Association not otherwise specifically provided for in this Constitution and By-Laws.

Sec. 2. Composition. The House of Delegates is composed of (1) delegates elected by the component county medical societies, (2) the officers and past presidents of the Association and (3) the delegates to the American Medical Association.

Will Read:

ARTICLE V.

House of Delegates

SEC. 1. COMPOSITION. The House of Delegates is composed of delegates elected by the component county medical societies as provided in the By-Laws. The general officers, the past presidents of the Association, the Treasurer, Editor of the JOURNAL, Delegates to the AMA, the Executive Secretary and Chairmen of Standing Committees shall be *ex-officio* members of the House of Delegates without the right to vote.

SEC. 2. DUTIES. The House of Delegates is the legislative body of the Association, and it shall transact all business of the Association not otherwise specifically provided for in this Constitution and By-Laws.

Now Reads:

ARTICLE VI.

Council

Sec. 1. The Council shall be the Board of Trustees and the Board of Censors of the Association. It shall carry out the mandates and policies as determined by the House of Delegates. The Council shall have full authority and power of the House of Delegates between sessions of that body. The Council shall have charge of all the property and financial affairs of the Association and shall perform such duties as are prescribed by law governing directors of corporations or as may be prescribed in the By-Laws.

Sec. 2. The Council shall consist of the President, President-Elect, the Immediate Past-President, the Secretary-Treasurer, and one Councilor from each Congressional District in the State of Georgia.

Will Read:

ARTICLE VI.

Council

SEC. 1. COMPOSITION. The Council is composed of the President, the President-Elect, the Immediate Past-President, two Vice-Presidents, the Secretary, the Speaker of the House of Delegates, and 10 Councilors as provided for in the By-Laws. The Treasurer, Editor of the JOURNAL, Executive Secretary and Delegates to the AMA shall be *ex-officio* members of Council without the right to vote. Vice-Councilors shall be *ex-officio* members except in the absence of their respective Councilors as provided for in the By-Laws. The Vice Speaker shall be an *ex-officio* member except in the absence of the Speaker as provided in the By-Laws.

SEC. 2. DUTIES. The Council is the Board of Trustees and the Board of Censors of the Association. It carries out the mandates and policies as determined by the House of Delegates. The Council has full authority and power of the House of Delegates between sessions of that body. The Council has charge of all the property and financial affairs of the Association and performs such duties as are prescribed by law governing directors of corporations or as may be prescribed in the By-Laws.

Now Reads:

ARTICLE VII.

Sessions and Meetings

Sec. 1. Annual Session. The Association shall hold an annual session during which there shall be general meetings open to all registered members, delegates and guests.

Sec. 2. Time and Place. The time and place for holding each annual session shall be fixed by the Council.

Sec. 3. Special Meetings. Special meetings of either the Association or the House of Delegates may be called by a two-thirds vote of the Council, twenty delegates or upon written petition of one-fourth of the members of the Association.

Will Read:

ARTICLE VII.

Meetings

SEC. 1. ANNUAL SESSION. The Association shall hold an Annual Session at a time and place fixed by Council.

SEC. 2. HOUSE OF DELEGATES. The House of Delegates shall meet during the Annual Session and in interim sessions as may be determined by Council.

SEC. 3. SPECIAL MEETINGS. Special meetings of either the Association or the House of Delegates may be called by a two-thirds vote of Council, 20 delegates or upon written petition of one-fourth of the members of the Association.

Now Reads:

ARTICLE VIII.

District Societies

In order to promote the best interests of the profession, the

House of Delegates shall provide for the division of the State into Councilor Districts, which shall be coextensive with the Congressional Districts in Georgia, and for the organization of all component county societies in the districts into Councilor District Medical Societies.

Will Read:

ARTICLE VIII.

District Societies

In order to promote the best interests of the profession, the House of Delegates shall provide for the division of the State into Councilor Districts and for the organization of all component county societies in the districts into Councilor District Medical Societies.

Now Reads:

ARTICLE IX.

Officers

Sec. 1. Officers. The officers of the Association shall be a President, President-Elect, two Vice-Presidents, Secretary-Treasurer, Speaker of the House of Delegates, Vice Speaker of the House of Delegates, and one Councilor and a Vice-Councilor from each of the Councilor Districts.

Sec. 2. Election and Eligibility. The officers of the Association shall be elected by the members during the annual session. No person shall be eligible to an elective office who has not been a member of the Association for the preceding three years.

Sec. 3. Terms of Officers. The President-Elect shall be elected annually. He shall become President on his installation at the close of the next annual session. If the President-Elect be unable to serve, both a President and a President-Elect shall be elected at the appropriate Annual Session. Other officers shall be elected for terms of one year each, except the Secretary-Treasurer, the Councilors and Vice-Councilors, who shall serve for three years. One-third, or as near as may be, of the Councilors and Vice-Councilors shall be elected annually.

Will Read:

ARTICLE IX.

Officers

SEC. 1. DESIGNATIONS. The officers of the Association shall be a President, President-Elect, two Vice-Presidents, the Immediate Past President, the Secretary, the Speaker of the House of Delegates, the Vice-Speaker of the House of Delegates, 10 Councilors and 10 Vice-Councilors as provided for in the By-Laws.

SEC. 2. ELECTION AND ELIGIBILITY. The officers of the Association shall be elected during the Annual Session as provided for in the By-Laws. No member shall serve as an officer who has not been a member of the Association for the preceding three years.

SEC. 3. TERM OF OFFICE OF PRESIDENT-ELECT. The President-Elect shall be elected annually and shall become President at the time of the next Annual Session. If the President-Elect shall be unable to serve, both a President and a President-Elect shall be elected at the appropriate Annual Session.

SEC. 4. TERMS OF OTHER OFFICERS. Other officers shall be elected for terms of one year each except the Secretary, Speaker of the House of Delegates, Vice-Speaker of the House of Delegates, and the Councilors and Vice-Councilors, who shall serve for three years. One third of the Councilors and Vice-Councilors shall be elected annually. All officers shall serve until their successors are elected and installed.

SEC. 5. SUCCESSOR TO THE PRESIDENT. If the President dies, resigns, or is removed from office, the First Vice-President shall immediately become President and shall serve for the remainder of the unexpired term. If the First Vice-President is unable to serve, then the Second Vice-President shall fill the office.

Now Reads:

ARTICLE X.

Funds and Expenses

Funds for the operation of the Association shall be raised by an equal *per capita* assessment on the members of each component county medical society. The amount of the assessment shall be set annually by the House of Delegates upon the recommendation of the Council. Funds may also be raised by voluntary contributions, from the Association's publications, and in any other manner approved by the House of Delegates.

The Council shall submit an annual budget for the next succeeding fiscal year to the House of Delegates. This budget shall not exceed the anticipated current income for the period covered by it. The Council shall manage the finances of the Association and shall supervise all funds, investments and expenditures of the Association. All resolutions providing for appropriations, recommended by the Council, shall be included in the annual budget, subject to final approval of the House of Delegates.

Will Read:

ARTICLE X.

Funds and Expenditures

Funds for the operation of the Association shall be raised by an equal per capita assessment on the members of each component county medical society. The amount of the assessment shall be set by the House of Delegates upon recommendation of Council. Funds may also be raised by voluntary contributions, from the Association's publications, and in any other manner approved by Council. The Council shall submit an annual budget to the House of Delegates and shall manage the finances of the Association.

Now Reads:

ARTICLE XIII.

Amendments

The House of Delegates may amend this Constitution by a two-thirds vote of the Delegates present at any annual session, provided that such amendment shall have been presented to the House of Delegates at the previous annual session and that it shall have been published during the year in The Journal of the Association, or sent officially to each component county society at least two months before the annual session at which final action is to be taken.

Will Read:

ARTICLE XIII.

Amendments

The House of Delegates may amend this Constitution at any session by a two-thirds vote of the Delegates present, provided that the proposed amendment shall have been introduced at the preceding session and provided that the proposed amendment shall have been published during the year in the JOURNAL.

Now Reads:

BY-LAWS

CHAPTER 1.

Membership

Sec. 1. Any physician holding the degree of Doctor of Medicine from a medical college acceptable to the Council of the Association, licensed to practice medicine in the State of Georgia, who has been a citizen of the United States for at least two years and who has not been adjudged guilty of moral turpitude or other serious crime, may be eligible for membership in a component society of the Association.

Will Read:

BY-LAWS

CHAPTER 1.

Membership

SEC. 1. A physician holding the degree of Doctor of Medicine or Bachelor of Medicine from a medical college acceptable to the Council of the Association, licensed to practice medicine in the State of Georgia, who has been a citizen of the United States for at least two years and who has not been judged guilty of moral turpitude or other serious crime, may be eligible for membership after being certified by the secretary of a component society as being a member in good standing of said component county society.

Now Reads:

Sec. 3. Membership in the Association shall be classified as active, associate, honorary, life and scientific.

Will Read:

SEC. 3. Membership in the Association shall be classified as Active, Service, Associate and Honorary.

Now Reads:

Sec. 4. Active Members. All members shall be active, including the right to vote and hold office, unless otherwise classified by action of the component county society.

Will Read:

SEC. 4. ACTIVE MEMBERS. Physicians who are members in a component county medical society and are eligible to vote and hold office in the society shall be Active members, unless otherwise classified by action of the component county society. These members shall have full privileges of Association membership including the right to hold office and vote, the privilege of Medical Defense and receipt of the JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, and these members shall pay full dues to the Association annually. New members entering practice after July 1st may pay one-half the annual dues.

Active members may be excused from the payment of Association dues for one of the following reasons: financial hardship or illness; post-graduate training, defined as that period during

which a member participates in an organized training course within a hospital; being retired from active practice; and on temporary service in the Reserve Armed Forces. A member excused from the payment of annual dues for service in the Armed Forces shall not be required to pay annual dues for the period beginning January 1 or July 1 following the date of the member's entrance into service. A member in good standing who is over 70 years of age may also be excused from the payment of Association dues upon his application to the Association through his component county society; this exemption to begin the year following the member's 70th birthday. Active members excused from the payment of Association dues shall have the right to vote and hold office but shall not have the privilege of Medical Defense and shall not receive any publication of the Association except by personal subscription. Nothing in this section shall be construed to be retroactive to affect previously elected Life Members.

Now Reads:

Sec. 5. Associate Members. Any physician who is not engaged in the regular practice of medicine for any one of the following reasons, namely: (1) during organized periods of hospital training and graduate education, (2) during periods of service in the Armed Forces, (3) after retirement or (4) for whom the payment of dues would constitute a hardship, may be classified by the component county society as an associate member. Associate Members shall be entitled to all the rights and privileges of the Association except that they shall not pay dues or receive The Journal without subscription thereto.

Sec. 6. Honorary Members. Eminent physicians and other persons who have distinguished themselves in the science of medicine, or for contributions to human welfare, may be elected to Honorary Membership in the Association by the House of Delegates upon nomination by any component county society and approval of the Committee on Professional Conduct of the Medical Association of Georgia. Such Honorary Members may be issued an appropriate certificate of membership without payment of dues.

Sec. 7. Life Members. A Life Membership may be granted by the House of Delegates, upon the recommendation of the component county society, to any physician who has had not less than forty years of active membership in the Association or has passed his seventieth birthday. He shall not be subject to payment of dues.

Sec. 8. Scientific Members. There shall be created a new division of membership to be known as Scientific Membership. The privileges of membership under this classification shall entitle the holder thereof to all phases of the Association's activities pertaining to the study of scientific medicine, and shall include the right to attend all scientific meetings, postgraduate study courses, and scientific sessions of component organizations. Scientific members shall pay no dues and shall not be entitled to vote or hold office. They shall not be entitled to Medical Defense or to receive The Journal except by regular subscription.

Sec. 9. A physician who is under sentence of expulsion from a component county society, or whose name has been dropped from its roll of members, shall not be entitled to any of the rights, privileges or benefits of the Association, nor shall he be permitted to take part in any of its proceedings.

Will Read:

SEC. 5. SERVICE MEMBERS. Physicians eligible for Service membership are all full-time commissioned Medical Officers in the Government in the U. S. Army, Navy, Air Force, United States Public Health Service, Veterans Administration, and Indian Service, and those physicians who have retired from the Services by federal law and who do not engage in active practice. Such members shall not be required to pay the annual dues and shall not be entitled to vote and hold office and shall not have the privilege of Medical Defense, nor shall they receive any publication of the Association except by personal subscription.

SEC. 6. ASSOCIATE MEMBERS. Associate membership may be granted to physicians who are engaged in State and County medical services and full-time salaried members of approved medical faculties not engaged in the private practice of medicine provided similar action has been taken by the component county society. Associate membership, except as otherwise provided herein, also may be granted to any member of a component county medical society. Associate members shall pay no dues and shall not be entitled to vote or hold office. They shall not be entitled to the privilege of Medical Defense or to receive any publication of the Association except by personal subscription.

SEC. 7. HONORARY MEMBERS. Physicians and persons holding the degree of Doctor of Philosophy who have risen to prominence in their professions may be elected to Honorary membership the House of Delegates. Nominations for Honorary membership may be submitted to the House of Delegates by component county societies or Council. These members shall enjoy all the privileges of the Association but shall not vote or hold office nor shall they receive the privilege of Medical Defense or any publication of the Association except by personal subscription.

SEC. 8. TENURE. When the Secretary is officially informed that a member is not in good standing in his component society, he shall remove the name of that member from the membership roll.

SEC. 9. TRANSFER. Should a member remove his practice to another jurisdiction he shall apply for a continuance of his membership through the component society in the jurisdiction to which he has moved his practice.

Now Reads:

Sec. 10. *The cause of the failure of a practicing physician to affiliate himself with an available component county society, at any time, shall be ascertained before election to membership.*

Will Read:

SEC. 10. Proposed complete deletion.

Now Reads:

Sec. 11. *Eligible physician members of the State and Federal medical services and full time members of approved medical faculties not engaged in private practice of medicine shall pay half the annual dues of the Association provided similar action has been taken by the component county society.*

Will Read:

SEC. 11. Proposed complete deletion.

Now Reads:

CHAPTER II.

General Meetings

Sec. 2. *The program for the general meetings shall be prepared by the Committee on Scientific Work and approved by the executive committee of the Council at least 60 days before the Annual Session of the Association and published in the issue of The Journal preceding the Annual Session.*

Sec. 3. *All papers read before the meetings shall become the property of the Association, and shall be deposited with the Secretary-Treasurer immediately after being read. Failure to comply with this and other rules set forth by the Committee on Scientific Work regarding papers, discussions and exhibits shall automatically bar scheduled participation in the scientific sessions in the future from this member for a period of not less than five years unless he presents an acceptable excuse.*

Sec. 4. *Upon invitation of the President any physician may register at a general meeting of the Association as a guest upon presentation of adequate evidence of membership in good standing in a component unit of the American Medical Association.*

Distinguished lay persons and physicians may be invited as special guests of the Association by the President or by action of the Council. Privileges of the floor may be extended to guests at the discretion of the presiding officer.

Will Read:

CHAPTER II.

SEC. 2. The program for the general meetings shall be prepared by the Council of the Medical Association of Georgia and approved by Council at least 60 days before the Annual Session of the Association and published in an issue of the JOURNAL preceding the Annual Session.

SEC. 3. All papers read before meetings shall be deposited with the Secretary or the presiding officer and shall become the property of the Association. Without an acceptable excuse, failure to comply with this and other rules as regard the Annual Session as set forth by the Council, shall automatically prohibit a member from participating in scheduled scientific sessions for a period of not less than five years.

SEC. 4. The general meetings shall be open to all registered members. Distinguished lay persons and guest physicians may be invited as special guests of the Association by the President or by action of Council.

SEC. 5. LOCAL ARRANGEMENTS COMMITTEE. As soon as practicable following the close of each Annual Session, the component society which will act as host at the next Annual Session shall elect Local Arrangements Committees which shall recommend suitable meeting places and shall have general charge of all local arrangements subject to the approval of Council.

Now Reads:

CHAPTER III.

House of Delegates

Sec. 1. *The House of Delegates shall meet on the first and*

last day of the annual session at a time fixed by the Council and at such other times as may be necessary for the transaction of the business of the Association.

Sec. 2. *Each component county society shall elect one delegate and a corresponding alternate for each twenty-five members, or fraction thereof, whose dues have been paid by December 31st of the preceding year, provided that each component county society shall be entitled to at least one delegate. It shall be the duty of the President to have the representation of each component county society checked by the Committee on Credentials at the time of the annual session, and to fill such vacancies by appointment. Such temporary appointees shall be members of the component society having the vacancy.*

Sec. 4. *The House of Delegates shall be presided over by the Speaker or, in his absence, by the Vice-Speaker. In the absence of both, a delegate agreeable to it may preside.*

Sec. 5. *The Secretary-Treasurer of the Association shall be the Secretary of the House of Delegates or, in his absence, by a delegate appointed by the President. The Executive Secretary may serve in this capacity.*

Sec. 6. *The following shall be the general Order of Business at all meetings of the House of Delegates: 1. Call to order by the President; 2. Roll Call; 3. Election of Speaker and Speaker pro tem; 4. Reading and adoption of minutes; 5. Reports of officers; 6. Reports of Committees; 7. Unfinished business; 8. New business.*

Sec. 7. *For the purpose of expediting proceedings the President shall appoint from the members of the House of Delegates the Reference Committees and other committees considered necessary. Any member of the Association may be appointed to serve on a committee created for a special purpose. Such members who are not members of the House of Delegates shall have the right to present their reports in person and to participate in the debate, but shall not have the right to vote.*

Will Read:

CHAPTER III.

House of Delegates

SEC. 1. MEETINGS. The House of Delegates shall meet during the Annual Session at a time and place fixed by Council. The House of Delegates may also meet in interim sessions and at such other times as may be necessary for the transaction of the business of the Association.

SEC. 2. Each component county society shall elect one delegate and a corresponding alternate, each of whom who has been a member in good standing for the prior three years, for each 25 members, or fraction thereof, whose dues have been paid by December 31st of the preceding year, provided that each component county society shall be entitled to at least one delegate. Delegates to the House of Delegates shall serve for a term of three years; one-third of the members of the House of Delegates to be elected annually provided that the component county societies, which are entitled to three or more delegates, shall elect at their first election, one-third of their delegation for a term of one year, one-third of their delegation for a term of two years and one-third of their delegation for a term of three years and thereafter elect such delegates whose terms of office expire therewith. Those component county societies which are entitled to less than three delegates shall elect their delegate or delegates for staggered terms in rotation as may be determined by Council until one-third of the House of Delegates is being elected annually.

SEC. 4. The House of Delegates shall be presided over by the Speaker or, in his absence, by the Vice-Speaker. In the absence of both, a delegate agreeable to it may preside. The Speaker and the Vice-Speaker shall be elected by the members of the House of Delegates and shall serve for a term of three years.

SEC. 5. The Secretary of the Association shall be the Secretary of the House of Delegates or, in his absence, a Delegate appointed by the Speaker of the House of Delegates shall serve as Secretary of the House of Delegates. The Executive Secretary may serve in this capacity.

SEC. 6. The following shall be the general Order of Business at all meetings of the House of Delegates: 1. Call to order by the Speaker; 2. Roll call; 3. Election of Speaker and Vice-Speaker (every third year at second session of House of Delegates during Annual Session; their terms of office to begin with adjournment of the House of Delegates; provided a Speaker and Vice-Speaker be elected as the next order of business after the adoption of this by-law); 4. Reading and adoption of minutes; 5. Re-

ports of officers; 6. Reports of committees; 7. Unfinished business; 8. New business.

At any meeting, the House by majority vote may change the Order of Business. New Business may be introduced at the final meeting of the House of Delegates only when such business is of an emergency nature or introduced by unanimous consent.

Sec. 7. For the purpose of expediting proceedings the Speaker of the House of Delegates shall appoint from members of the House of Delegates the reference committees, the credentials committee, and other committees considered necessary. Any member of the Association may be appointed to serve on a committee created for a special purpose. Such members who are not members of the House of Delegates shall have the right to present their reports in person and to participate in debate, but shall not have the right to vote.

Now Reads:

Sec. 9. The House of Delegates shall nominate members of all Boards required by the Laws of Georgia.

Will Read:

Sec. 9. Proposed complete deletion.

Now Reads:

CHAPTER IV.

Council

Sec. 1. The Council shall meet on the last day of the annual session of the Association to organize and at intervals of not more than four months apart until the next annual session. Special meetings of the Council may be held on the call of the President or upon request of three members of the Council.

Sec. 2. The Council shall be composed of the President, the President-Elect, Vice-Presidents, Secretary-Treasurer, and one Councilor or Vice-Councilor from each Councilor district. Each Councilor and Vice-Councilor shall be nominated by each district society at the time of its annual meeting. In the event of a vacancy in the office of a Councilor and Vice-Councilor, the vacancy may be filled temporarily by appointment by the President from members of that district society.

Sec. 3. The Council shall set up an Executive Committee composed of the President, Secretary-Treasurer, Chairman of the Council and two other members of the Council. The President shall be the chairman of the Executive Committee. It shall meet not less often than bi-monthly to review the affairs of the Association. The Committee shall make recommendations to the Council and shall carry out such items of business as are referred to it by the Council.

Sec. 4. The Chairman of the Council shall be elected annually at the organization meeting and shall serve one year, or until his successor is elected. He shall preside over its meetings and appoint all necessary committees. A Vice-Chairman shall be elected from among its members. The Secretary-Treasurer of the Association shall be the Secretary of the Council.

Sec. 5. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the powers conferred on the House of Delegates by the Constitution and By-Laws.

Sec. 6. The Council shall be the Board of Censors of the Association. It shall consider all questions involving the right and standing of members, whether in relation to other members, to the component societies or to the Association. Any question of an ethical nature may be brought before the Council by the Committee on Professional Conduct or by any member of the Association. It shall hear and decide all questions of discipline affecting the conduct of members of component societies, on which an appeal is taken from the decision of a component society. Its decision in all cases, including questions regarding membership in the Association, shall be final subject to approval of the House of Delegates.

Sec. 7. Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of, and to aid in, the betterment of the component societies in his district. He shall make an annual report of his work, listing all eligible physicians in his district who are not members of a component society and of the condition of the profession of each county in his district at the annual session of the House of Delegates. The Vice-Councilor shall assist the Councilor in the performance of his duties. He becomes a voting member of the Council only in the absence of the Councilor from his district.

Sec. 8. Charters for county and district societies shall be issued on approval of the Council and shall be signed by the President and Secretary-Treasurer of the Association. Upon the

recommendation of the Council, the House of Delegates may revoke the charter of any society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

Sec. 9. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designated so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all the rights and privileges provided for component societies until such counties shall be organized separately. A physician residing in a county not having a component society shall be referred to an adjacent component county society by the Council for consideration for membership. Choice of any other component county society by such a physician for membership shall be made only with the full consent of all component societies involved.

Sec. 10. The Council shall provide for and superintend the issuance of all necessary publications of the Association, including proceedings, transactions and memoirs.

Sec. 11. The Chairman of the Council shall appoint from among its members, a committee of three members to be known as the Committee on Auditing and Appropriations, which shall cause to be audited all accounts of the Association. The Council shall propose an annual budget for the fiscal year beginning January 1st after each annual session. This proposed budget shall be prepared by the Committee on Auditing and Appropriations for the consideration of the Council at the last meeting in the last quarter of each year. This budget shall be presented to the House of Delegates for its approval after which it becomes effective. It shall also submit an annual report to the House of Delegates, which shall specify the character of all of its property and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

Sec. 12. The Council shall authorize the payment of all necessary expenses incurred by the officers of the Association in the performance of their duties, except those incurred during the annual session. The Council, also, may authorize a special fund to be made available to the President of the Association, who may expend all or any part of it for the good of the Association without restriction.

Sec. 13. The Council shall appoint, at least six months before the annual session, a committee, consisting of three or more of its members, to be known as the Committee on Arrangements for the annual session. This committee shall appoint a general chairman of a local committee on arrangements, who shall be a member of the component society in which the annual session is to be held. This local Chairman shall appoint, from the members of his county society, the personnel of the local committee on arrangements. The local committee on arrangements shall provide suitable meeting places and shall have general charge of all local arrangements subject to the approval of the Committee on Arrangements for the annual session. All expenditures made by that committee in connection with the annual session must be authorized in advance by the Committee on Auditing and Appropriations of the Council. Immediately after the annual session the Committee on Arrangements of the Council shall forward to the Secretary-Treasurer any accumulated balance. Auditing and Appropriations.

Sec. 14. The Council shall by appointment fill any vacancy in office not otherwise provided for which may occur during the interval between annual sessions of the Association. The appointee shall serve until his successor has been elected and installed.

Sec. 15. The Council may appoint an Assistant Secretary-Treasurer or an Executive Secretary—either or both and fix their terms of employment.

Sec. 16. The Council shall determine the employment and salaries of all personnel necessary to conduct the affairs of the Association subject to approval of the House of Delegates.

Sec. 17. The Council shall provide such headquarters for the Association as may be required to conduct its affairs.

Sec. 18. The Council shall have control of all technical exhibits at the annual sessions.

Sec. 19. The Council shall fix the bond of the Secretary-Treasurer and all other necessary personnel of the Association.

Sec. 20. The Council shall have full and complete charge of all public relations of the Association, subject only to the House of Delegates.

Will Read:

CHAPTER IV.

SEC. 1. COMPOSITION. The Council is composed of the President, the President-Elect, the Immediate Past President, two

Vice-Presidents, the Secretary, Speaker of the House of Delegates, or the Vice-Speaker of the House of Delegates, and one Councilor or Vice-Councilor from each Councilor District. Vice-Councilors shall be *ex-officio* members of Council, without the right to vote, except in the absence of their respective Councilors when they shall serve as Councilor. The Vice-Speaker shall be an *ex-officio* member of Council without the right to vote except in the absence of the Speaker when he shall serve in the Speaker's stead. The Treasurer, Editor of the JOURNAL, Executive Secretary, and Delegates to the AMA shall be *ex-officio* members of Council without the right to vote.

SEC. 2. CHAIRMAN AND SECRETARY. A Chairman and a Vice-Chairman of Council shall be elected annually at the organizational meeting and shall serve for one year, or until their successors are elected. The Chairman or Vice-Chairman shall preside over meetings of Council and appoint all necessary committees of Council. The Secretary of the Association shall serve as Secretary of Council. The Council may designate the Executive Secretary or Assistant Executive Secretary to serve in this capacity.

SEC. 3. EXECUTIVE COMMITTEE. The Council shall organize an Executive Committee at the organizational meeting. The Executive Committee shall be composed of the President, the President-Elect, the Immediate Past President, the Secretary, the Chairman of Council, who shall serve as presiding officer, and the Chairman of the Council Committee on Finance. It shall meet monthly between the meetings of Council. The Committee shall make such recommendations to the Council and shall carry out such items of business as are referred to it by Council. The committees of the Association and nominate members of all shall serve as Publications Committee of the JOURNAL. The Executive Committee shall appoint all committee chairmen and boards required by the laws of the State of Georgia on recommendation of the District Societies where applicable; not otherwise provided for, subject to confirmation by Council, and Executive Committee shall appoint a Treasurer of the Association annually as provided for in these By-Laws. The Executive Committee shall recommend to Council the terms of employment and salaries of all personnel necessary to conduct the affairs of the Association. The Executive Committee shall be empowered to select an Executive Secretary who shall be responsible to the Executive Committee for his action and for the operation of the Headquarters Office, subject to the approval of Council. The Executive Committee shall act as a Board of Trustees directing the Executive Secretary in carrying out the mandates and policies of the Council and the House of Delegates.

SEC. 4. MEETINGS. The Council shall meet at the close of the Annual Session to organize and at intervals of not more than four months until the next Annual Session. Special meetings of Council may be held on the call of the President or upon the request of three members of Council. Regular meetings of Council will be held on the call of the Chairman.

SEC. 5. GENERAL DUTIES. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the powers conferred on the House of Delegates by the Constitution and By-Laws. The Council shall provide such headquarters for the Association as may be required to conduct its affairs. The Council shall by appointment fill any vacancy in office not otherwise provided for, which may occur during the interval between Annual Sessions of the Association. The appointee shall serve until his successor has been elected and installed.

The Council shall authorize the payment of all necessary expenses incurred by the officers of the Association in the performance of their duties, except those incurred during the Annual Session. The Council, also, may authorize a special fund to be made available to the President of the Association, who may expend all or any part of it without restriction for the good of the Association.

SEC. 6. SPECIFIC DUTIES. The Council shall determine the employment and salaries of all personnel necessary to conduct the affairs of the Association on the recommendation of the Executive Committee of Council. The Council shall control and direct all Association publications.

SEC. 7. BOARD OF CENSORS. The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies or to the Association referred to it by the Association's Professional Conduct Committee. Any question of an ethical nature may be brought before the Council by the Committee on Professional Conduct or by any

member of the Association or upon the request of the party concerned on which an appeal is taken from the decision of the Association's Professional Conduct Committee. It shall hear and decide all questions of discipline affecting the conduct of members of component societies, on which an appeal is taken from the decision of a component society or the Association's Professional Conduct Committee. Its decision in all cases, including questions regarding membership in the Association, shall be final subject to approval of the House of Delegates.

SEC. 8. COUNCILOR AND VICE-COUNCILOR DUTIES. Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of, and to aid in the betterment of, the component societies in his district. He shall make an annual report of his work, listing all eligible physicians in his district who are not members of a component society and of the condition of the profession of each county in his district at the Annual Session of the House of Delegates. The Vice-Councilor shall assist the Councilor in the performance of his duties. He becomes a voting member of the Council only in the absence of the Councilor from his district.

SEC. 9. COMMITTEE ON FINANCE. The Chairman of the Council shall appoint from among its members a committee of three members to be known as the Committee on Finance, which shall cause to be audited all accounts of the Association. The Council shall propose an annual budget for the fiscal year beginning January 1st after each annual session. This proposed budget shall be prepared by the Committee on Finance for the consideration of the Council at the last meeting in the last quarter of each year. This budget shall be presented to the House of Delegates for its approval. It shall also submit an annual report to the House of Delegates, which shall specify the character of all of the Association's property and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

All expenditures made by the Local Arrangements Committees in connection with the Annual Session must be authorized in advance by the Committee on Finance. Council shall have control of all commercial exhibits at the Annual Sessions and any deficit created on account of the annual session shall be met by Council on recommendation of the Committee on Finance.

- SEC. 10. Proposed complete deletion.
- SEC. 11. Proposed complete deletion.
- SEC. 12. Proposed complete deletion.
- SEC. 13. Proposed complete deletion.
- SEC. 14. Proposed complete deletion.
- SEC. 15. Proposed complete deletion.
- SEC. 16. Proposed complete deletion.
- SEC. 17. Proposed complete deletion.
- SEC. 18. Proposed complete deletion.
- SEC. 19. Proposed complete deletion.
- SEC. 20. Proposed complete deletion.

Now Reads:

CHAPTER V.

Election of Officers

Sec. 1. The President-Elect, Vice-Presidents, Secretary-Treasurer, Councilors and Vice-Councilors shall be elected by ballot by the members of the Association. Nominations for these officers except Councilors and Vice-Councilors shall be made orally as the last order of business at the first meeting on the first day of the scientific session. No nominating or seconding speech shall exceed two minutes. The President shall appoint a Committee of not less than three Tellers immediately after the close of nominations who shall have charge of the election.

Sec. 2. Nominations for Councilors and Vice-Councilors shall be made by each district society at its annual meeting and forwarded by its secretary to the Secretary of the Association not later than 15 days before the annual session. If no nomination is presented by a district society in this manner, nominations for Councilor and Vice-Councilor from such district shall be made from the floor. One third of the Councilors and Vice-Councilors shall be elected annually.

Sec. 3. The Secretary-Treasurer shall have prepared in advance an official ballot. One ballot shall be given to each active voting member when he presents himself to cast his ballot. Such member and no other shall prepare his ballot and shall deposit it at that time in a locked ballot box provided by the Secretary-Treasurer and kept in the custody of the Tellers designated by the President. The key shall be kept by the Chairman of the Tellers.

Sec. 4. Voting shall take place during the hours of the scientific program up to 10:30 a. m. of the last day of the annual session. At that time the Committee of Tellers appointed by the President shall count the ballots and report their findings to the members at the last meeting of the Association. The candidate for President-Elect receiving a majority of the votes shall be declared elected, but if no majority is received on the first ballot, the members present shall select the President-Elect from the two candidates having the highest number of votes by secret ballot. Other officers shall be elected by receiving the highest number of votes on the first ballot.

Will Read:

CHAPTER V.

Election of Officers

SEC. 1. ELECTION. The President-Elect, two Vice-Presidents, Secretary, Councilors and Vice-Councilors shall be elected by ballot by the members of the Association during the Annual Session. The President-Elect shall be elected annually and shall become President at the time of the next annual session. The Speaker of the House of Delegates and Vice-Speaker of the House of Delegates shall be elected by members of the House of Delegates and shall serve for a term of three years. Other officers shall be elected for terms of one year each except the Secretary, Councilors and Vice-Councilors who shall serve for three years. One-third of the Councilors and Vice-Councilors shall be elected annually.

SEC. 2. NOMINATIONS. Nominations for these officers except the Speaker and Vice-Speaker and the Councilors and Vice-Councilors shall be made orally from the floor as the last order of business at the first General Session of the Annual Session and no nominating or seconding speech shall exceed two minutes. Nominations for Speaker and Vice-Speaker shall be made by members of the House of Delegates orally on the floor of the House of Delegates as provided in the House of Delegates order of business. Nominations for Councilors and Vice-Councilors shall be made by each district society at its annual meeting and forwarded by its secretary to the Secretary of the Association not later than 15 days before the annual session. If no nomination is presented by a district society in this manner, nominations shall be made from the floor.

SEC. 3. METHOD. The President shall appoint a committee of not less than three Tellers immediately after the close of nominations, who shall have charge of the election. The Secretary shall have prepared in advance an official ballot and an official ballot box, which shall be kept in the custody of the Tellers Committee. One ballot *only* shall be given to each active voting member when he presents himself to cast his ballot. Such member and no other shall prepare his ballot and shall deposit it at that time in the locked ballot box.

The candidates for office receiving a majority of the votes shall be declared elected, but if no majority is received on the first ballot, the members present shall select by secret ballot the officer from the two candidates having the highest number of votes.

SEC. 4. TIME. Voting shall take place during the hours of the scientific program up to the beginning of the last meeting on the last day of the Annual Session. At that time the Committee of Tellers shall count the ballots and report their findings to the members.

Now Reads:

CHAPTER VI.

Duties of Officers

Sec. 1. The President. The President shall preside at the organization meeting of the House of Delegates and at all meetings of the Association and shall appoint all committees not otherwise provided for. He shall deliver an address at such time during the annual session as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession and of the Association in the State during his term of office. So far as practicable he shall visit by appointment the various district societies, and shall assist the Councilors in building up the county societies, and in increasing the prestige of the Association. He shall be a member of the Council and its Executive Committee, and shall be a member of all committees of the Association with the authority to call a meeting of any Committee when necessity demands it or after failure of the chairman to do so. With the consent of the Council he shall terminate any committee whose function has been fulfilled. It shall be his duty with the approval of the Council, to replace any member of any committee who fails to show interest in performing the duties assigned to him.

Sec. 2. The President-Elect. The President-Elect shall be a member of the Council, and shall be a member *ex-officio* of all

standing committees. In order to acquaint himself with all the activities of the Association, it shall be his duty to attend all meetings of the Council and the Standing Committees.

Sec. 3. The Vice-Presidents. The Vice-Presidents shall assist the President in the discharge of his duties. Upon request or in the absence of the President, the Vice-Presidents will preside over the general meetings of the Association in rotation. In the event of the President's death, resignation, or inability to serve, the Vice-Presidents, in their order shall succeed him for the unexpired term.

Sec. 4. The Secretary-Treasurer. (a) The Secretary-Treasurer or his representative shall attend the general meetings of the Association and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings in separate record books. He shall be Secretary of the Council and its Executive Committee and an *ex-officio* member of all committees.

Sec. 4. (b) He shall be custodian of all record books and papers belonging to the Association and shall keep account of all funds of the Association which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card-index register of all the legal practitioners of the State by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall supply all component societies with the necessary blanks for making their annual reports, and shall collect the regular per capita assessments from the component societies. The amount of his salary shall be fixed by the Council.

Sec. 4. (c) He shall give bond in the amount of a sum to be fixed by the Council. He shall receive all funds of the Association, together with bequests and donations. He shall pay money out of the treasury only on authorization of the Council; he shall furnish a balance sheet to the Council at the last meeting of the fiscal year at the annual session of the Association. This shall consist of an itemized statement of all financial transactions of the past year, all accounts made, money received and disbursed with vouchers attached. The fiscal year includes the period of time between January 1st and December 31st. This financial report shall be published in *The Journal* as soon as practicable after the end of each fiscal year.

Will Read:

CHAPTER VII.

Rights and Duties of Officers

SEC. 1. PRESIDENT. The President shall (A) preside at all general meetings of the Association; (B) address the opening General Session of the Annual Session; (C) assist the Councilors in improving the county and district societies as far as practicable; (D) serve as a member of Council and as a member of its Executive Committee; (E) serve as a member of all committees of the Association with the authority to call a meeting of any committee when necessity demands it or after failure of the chairman to do so. With the approval of Council, he may terminate any committee whose function has been fulfilled or replace any member of any committee who fails to show interest in performing the duties assigned to him; (F) he shall be an *ex-officio* member of the House of Delegates without the right to vote.

SEC. 2. PRESIDENT-ELECT. The President-Elect shall be a member of the Council and of its Executive Committee, and shall be a member *ex-officio*, without the right to vote, of all Standing Committees. In order to acquaint himself with all the activities of the Association, it shall be his duty to attend all meetings of the Council and, when possible, the Standing Committees. He shall be an *ex-officio* member of the House of Delegates without the right to vote.

SEC. 3. THE VICE-PRESIDENTS. The Vice-Presidents shall be members of the Council. The Vice-Presidents shall assist the President in the discharge of his duties. Upon request or in the absence of the President, the Vice-Presidents will preside over the general meeting of the Association in rotation. In the event of the President's death, resignation, or inability to serve, the Vice-Presidents in their order shall succeed him for the unexpired term. The Vice-Presidents shall be *ex-officio* members of the House of Delegates without the right to vote.

SEC. 4. SECRETARY. (A) The Secretary and the Executive

exerted for bettering the scientific, moral and material conditions of its members. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every acceptable and eligible physician in the county or counties in its jurisdiction.

SEC. 6. DUTIES. Each component county society shall meet the following five minimum standards: Each society shall (1) meet a minimum of four times a year, elect officers and delegates annually at a meeting before January 1st and report these officers to the headquarters office before January 1st; (2) maintain an up to date Constitution and By-Laws in conformity with the Constitution and By-Laws of the Medical Association of Georgia and shall transmit a copy of its Constitution and By-Laws to the headquarters office for record; (3) maintain a Board of Censors and/or a Mediation Committee; (4) maintain minutes of each meeting in a permanent record book that will be available at all times; (5) maintain scheduled programs at its minimum four meetings annually.

SEC. 7. DELEGATES. Each component county society shall elect at its annual meeting prior to January 1st Delegates and Alternates to the House of Delegates in accordance with these By-Laws. The secretary of each component society shall send a list of such delegates to the Secretary of the Association before January 15th. In the absence of, or the disability or disqualification of, a Delegate, the vacancy may be filled by the President of the society from other members of the same component society, provided such vacancy is filled prior to the first session of the House of Delegates.

SEC. 8. COMBINED COUNTIES. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designated so as to distinguish them from district societies. These societies when chartered shall be entitled to all the rights and privileges provided for component societies. A physician residing in a county not having a component society shall be referred to an adjacent component county society by Council.

SEC. 9. ANNUAL MEETING. Each component county society shall designate a meeting held prior to January 1st as its annual meeting, at which time Officers and Delegates for the next year shall be elected and their names forwarded before January 15th to the Secretary of the Association.

SEC. 10. DISTRICT SOCIETIES. District Societies shall have one or more meetings during the year and shall nominate a Councilor and Vice-Councilor as provided in these By-Laws. These district societies shall be organized for the best interests of the medical profession in Georgia and shall not necessarily conform with the boundaries of congressional districts. District societies shall elect officers, adopt a Constitution and By-Laws in conformity with the Constitution and By-Laws of the Medical Association of Georgia and levy dues for the government of its own affairs.

SEC. 11. Proposed complete deletion.

Now Reads:

CHAPTER VIII.

Dues and Assessments

Sec. 1. *The annual dues and assessments shall be determined by the House of Delegates upon recommendation of the Council and shall be levied per capita on the members of the Association. They shall be payable on or before January 1st of the year for which they are levied. The secretary of each component county society shall cause to be collected and shall forward to the office of the Association the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the Secretary-Treasurer of the Association on or before April 1st, shall stand suspended until his name is properly reported and his dues for the current year properly remitted. At no time and under no circumstances shall a member make payment of dues or assessments directly to the Secretary-Treasurer of the Association. Neither shall the Secretary-Treasurer of the Association receive payments of dues or assessments from anyone except the secretary of the component county society or his representative.*

An active member who fails to pay dues for one or more years current year plus one year's dues in arrears subject to reapplication and approval by his county society.

Sec. 2. *The record of payment of dues and assessments on file in the office of the Association shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Association and of the House of Delegates.*

Sec. 3. *For the purpose of medical defense a member shall be deemed in arrears from and during the period extending April*

1st of the current year until his dues and assessments shall have been received at the office of the Association, having been remitted by the secretary of the component county society of which he is a member.

Sec. 4. *Any county society which fails to make the reports required before the annual session of the Association, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Association or of the House of Delegates.*

Will Read:

CHAPTER VIII.

Funds and Expenditures

SEC. 1. TREASURER. The Treasurer shall be appointed annually by the Executive Committee of Council subject to the approval of Council. The Treasurer shall be a member in good standing for at least three years prior to his appointment and may be the same person as the Secretary. The Treasurer shall not be an officer of the Association but shall be an *ex-officio* member, without the right to vote, of Council and the House of Delegates. He shall be an *ex-officio* member, without the right to vote, of the Committee on Finance. The Treasurer shall give bond in such sum as may be fixed by the Council, the premium on such bond to be paid by the Association.

SEC. 2. TREASURER'S DUTIES. The Treasurer shall receive all funds of the Association together with bequests and donations. He shall pay money out of the treasury only on authorization of the Council; he shall furnish a balance sheet to the Council at its last meeting of the fiscal year. The fiscal year includes the period of time between January 1st and December 31st inclusive. A financial report shall be published in THE JOURNAL as soon as practicable after the end of each fiscal year. All checks for Association expenditures shall be signed by both the Treasurer and the Secretary, or by any two officers of the Association designated by Council.

SEC. 3. DUES AND ASSESSMENTS. (A) The annual dues and assessments shall be determined by the House of Delegates upon recommendation of the Council and shall be levied per capita on the active members of the Association. They shall be payable on or before January 1st of the year for which they are levied. The secretary of each component county society shall cause to be collected and shall forward to the office of the Association before January 1st the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the headquarters office of the Association on or before April 1st, shall stand suspended until his name is properly reported and his dues for the current year properly remitted. At no time and under no circumstances shall a member make payment of dues or assessments directly to the headquarters office of the Association. Neither shall the headquarters office of the Association receive payments of dues or assessments from anyone except the secretary of the component county society or his representative.

An active member who fails to pay dues for one or more years shall be eligible for reinstatement upon payment of dues for the current year plus one year's dues in arrears subject to reapplication and approval by his county society.

SEC. 3.(B) The record of payment of dues and assessments on file in the office of the Association shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Association and of the House of Delegates.

SEC. 3.(C) For the purpose of medical defense a member shall be deemed in arrears from and during the period extending April 1st of the current year until his dues and assessments shall have been received at the office of the Association, having been remitted by the secretary of the component county society of which he is a member.

SEC. 3.(D) Any county society which fails to make the reports required before the annual session of the Association shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Association or of the House of Delegates.

Now Reads:

CHAPTER IX.

Standing Committees

Sec. 1. *The Standing Committees of the Association shall be as follows:*

- (A) *Committee on Scientific Work*
- (B) *Committee on Legislation*
- (C) *Committee on Medical Education*

- (D) Committee on Medical Defense
- (E) Committee on Professional Conduct
- (F) Committee on History and Vital Statistics
- (G) Committee on Public Health
- (H) Committee on Maternal and Infant Welfare
- (I) Committee on Rural Health
- (J) Committee on Industrial Health
- (K) Committee on Public Relations
- (L) Committee on Cancer
- (M) Committee on Insurance
- (N) Committee on Veterans Affairs
- (O) Committee on Constitution & By-Laws
- (P) Committee on Awards
- (Q) Committee on Woman's Auxiliary
- (R) Committee on Hospitals

Sec. 2. Unless otherwise provided in these By-Laws, each of these committees shall consist of three members, each of whom shall serve for three years. One member of each standing committee shall be appointed each year by the President to serve for three or more years as required by each committee and announced at the time of the final meeting of the Association each year. Provided that for the first year the President shall appoint three or more members as required with one member to serve for the necessary graduated period of years to meet these requirements. Failure of a member to carry out the duties of his committee assignment during any year shall automatically cause his removal at the time of the annual session and the President, with the consent of the Council, shall appoint another member to fill his unexpired term. All committees shall make an annual report in writing to the Association headquarters office sixty days in advance of the Annual Session.

(A) The Committee on Scientific Work. The Committee on Scientific Work shall be composed of five members: the President, the Secretary-Treasurer and three members appointed for terms of three years each. The senior appointed member shall serve as chairman. The duties of the Committee on Scientific Work shall be to prepare and publish the Scientific Program of the annual session, subject to the approval of Council. It shall also prepare and publish all rules and regulations governing the selection and presentation of papers, discussions and Scientific Exhibits before the general meetings and shall present them for publication in The Journal of the Association.

The presentation of Scientific Exhibits for the annual session shall be under the direction of this committee. For this purpose, the committee may set up a sub-committee of three or more members with representatives from the two medical schools of the State.

All lectureships of the Association shall be under the control of this committee, but special sub-committees may be established to advise the committee concerning the selection of proper speakers for each lectureship. These special lectures shall be given before the general meetings at a time selected by the Committee on Scientific Work.

(B) The Committee on Legislation. The duties of the Committee on Legislation shall be to represent the Association in securing and enforcing legislation in the interests of public health and of scientific medicine. It shall keep in touch with professional and public opinion, shall endeavor to shape legislation so as to secure the best results for the whole people, and shall strive to organize professional influence so as to promote the general good of the community in local and national affairs. It shall further the education of the general public in health matters fostering a sane point of view about proper medical care.

Each component county society and district society shall designate one member at its annual meeting to serve with the Committee on Legislation in an active capacity. Vacancies in this special sub-committee shall be filled by the President. In addition, the Woman's Auxiliary shall be requested to form a similar committee with representatives from each component auxiliary. The President may appoint for one year an Advisory Committee of any number he deems advisable.

(C) The Committee on Medical Education shall consider and devise means of extending the educational work of the Association for the benefit of its members, working with the component societies whenever possible and serve for the Council on Medical Education of the American Medical Association in this state. All problems relating to the postgraduate study of medicine shall be referred to this committee.

(D) The Committee on Medical Defense. The Committee on Medical Defense shall consist of five members, of whom the Chairman of the Council and the Secretary-Treasurer shall be members. The other members, one of whom shall be elected Chairman, shall be elected by the Council for terms of five years

each. The duties of this committee shall be to investigate and defend all damage suits brought against the Medical Association of Georgia; to investigate all claims of alleged malpractice made against its members and to take full charge of such cases that are deemed to be worthy of defense; to defend all such cases in the courts of last resort, to furnish General Counsel and pay court costs usual to such litigation, and reasonable fees for local attorneys as shall be arranged by Council. Any member who has indemnity insurance shall have such insurance bear its portion of the expense. However, they shall not pay, or obligate The Medical Association of Georgia to pay any judgment rendered against any member upon the final determination of any case. It shall be empowered to contract with such agents and attorneys as it may deem necessary for the proper carrying out of this By-Law. The assistance for defense, as herein provided shall be available only to members of The Medical Association of Georgia in good standing.

Any member of the Association threatened with suit for alleged civil malpractice shall immediately communicate with the Secretary-Treasurer of the Association and shall give full and complete information in reference to all the circumstances alleged in the complaint. He shall immediately notify the Chairman of this committee who shall investigate the circumstances reported and shall advise with the attorneys or agents employed by the committee for this purpose. The member sued, or threatened with suit, shall be consulted and shall have the complete confidence of the committee in all transactions connected with the investigation in question. The committee shall have the authority to require of a constituent society or the president thereof, the appointment of a committee of investigation in any such case, and it may direct the committee so appointed to report to the Committee on Medical Defense and not to the society from which it was appointed.

The Committee on Medical Defense may assist in the prosecution of illegal practitioners in the State of Georgia and assist in the enforcement of the Medical Practice Act of this State.

(E) The Committee on Professional Conduct. The Committee on Professional Conduct shall consist of the five most recent past presidents of the Association. The senior member shall be Chairman. It shall investigate all complaints relating to or involving the ethical or professional practice of any member of The Medical Association of Georgia. All complaints or accusations against any member of The Medical Association of Georgia relative to irregular practice, excessive fees, habitual failure to respond to calls without adequate reason, extravagant or questionable statements made as witnesses in a court of law, or any act calling for disciplinary measures or investigations of a member, shall become the concern of this Committee. Complaints may be made by an individual patient, physician, board of censors of any local medical society, attorney, or any officer of a regularly constituted court of law. Upon receipt of notice of such complaint, the Committee, through its individual members or some competent person designated by it, shall immediately investigate the charges, and if the Committee is convinced that there is sufficient justification for a hearing the physician shall be requested to appear before at least three members of said Committee to answer charges. Such hearing shall be conducted in private and the source of information and charges will be divulged only at such hearing. No member of this Committee shall sit in a hearing involving a physician from his Councilor District.

After deliberation, the Committee shall have a choice of one of the four following dispositions:

1. Dismiss the case because of insufficient grounds for a legitimate complaint.
2. Attempt a satisfactory adjudication of the complaint.
3. Suggest to the physician changes in his conduct and relationship with his patients, in order that he may not bring unfavorable criticism upon his profession.
4. Refer to the Council of The Medical Association of Georgia all cases in which action by the Council is deemed necessary, together with recommendations as to disciplinary measures to be taken by the Council of The Medical Association of Georgia.

Nothing in this By-Law shall be construed to prevent the selection and active participation in all the functions enumerated above by each component county society.

(F) The Committee on History and Vital Statistics. It shall be the duty of the Committee on History and Vital Statistics to stimulate and promote the preparation of suitable articles on the history of the Association and its members, and shall recommend their publication to The Journal of the Association. It

shall prepare memorials for deceased members, and arrange for their publication. It shall also report to the House of Delegates all new and eligible physicians who were licensed in the State during the past year indicating those who have become members of the Association. The Editor of The Journal and the President of the State Board of Medical Examiners shall be ex-officio members of this committee.

(G) The Committee on Public Health. The Committee on Public Health shall be assisted by a sub-committee of one member elected by each county and district society of the state. Its duty shall be to advise with the Governor and other State officials, and with the Georgia State Board of Health and other related groups in regard to all matters concerning the health of the citizens of Georgia. It shall meet at the time of each session of the Georgia State Legislature with the Committee on Legislation to give assistance in carrying out its duties.

The President may appoint for one year an Advisory Committee of any number he deems advisable.

(H) The Committee on Maternal and Infant Welfare shall be composed of seven members, three of whom shall be general practitioners. It shall regularly review and analyze the causes of all maternal deaths occurring in the State. It shall investigate conditions affecting maternal care in Georgia and make recommendations concerning improvements thereof. It shall establish a working liaison with the Georgia State Obstetrical and Gynecological Society and the Georgia Pediatric Society and shall consider the establishment of annual post-graduate regional courses in obstetrics throughout the State with the cooperation of the Committee on Medical Education and Hospitals.

(I) The Committee on Rural Health shall concern itself with improving medical service in the more sparsely settled areas in the State. It shall be composed of one member from each of the Councilor Districts comprising the Association, in addition to the Director of the State Department of Public Health who shall be a member ex-officio. It shall investigate and make recommendations as to locating and staffing health centers and shall cooperate with the Council on Rural Health of the American Medical Association. The Committee shall designate a member to represent the Medical Association of Georgia at national conferences on rural health.

(J) The Committee on Industrial Health shall be composed of five members. The committee shall confer with both labor and management in stressing the importance of preventive rather than curative medicine. It shall investigate and make recommendations concerning the initiation of programs designed to improve safe working conditions for employees and to solve other industrial health problems. It shall cooperate in all respects with the Council on Industrial Health of the American Medical Association.

(K) The Committee on Public Relations shall be appointed by the President. It shall be the duty of the committee to integrate and publicize all approved plans and projects emanating from the Council and other standing and special committees of the Association. It shall consider all policies and make suggestions and recommendations for improving or changing such policies for the purpose of integration and publicizing. It shall develop additional projects for bettering understanding between physicians and the public.

(L) The Committee on Cancer shall consist of one representative from the Association, one from each of the State-Aid Cancer Clinics, and one each from the Medical Colleges in the State who shall serve not less than three years, and the President shall appoint the chairman from among the members having the longest service. The chairman shall submit a list of physicians' names representing these groups for appointment by the President. An Executive Committee of this committee consisting of not less than six members shall be appointed by the President upon recommendation of the chairman.

It shall be the duty of this committee to represent the members of the Association in dealing with all matters pertaining to cancer, and in particular, it shall advise with the Division of Cancer Control of the Department of Public Health.

(M) The Committee on Insurance or Insurance Board shall consist of not less than five members appointed for a period of five years in rotation by the President. The committee may elect one of its members to be chairman or request the President to designate a member as chairman. Members appointed during the first four years shall serve staggered terms as designated by the President.

The four geographical quadrants and the central industrial area shall have representation on this committee. Also the chairman may nominate five lay persons with known interest in the

field of insurance for appointment by the President, who shall serve with the Board in an advisory capacity.

It shall be the duty of this committee to formulate and administer all policies and plans pertaining to insurance insofar as such concern members of the Association. In particular it shall sponsor and promote the Georgia Plan including provision for necessary expenses.

(N) The Committee on Veterans Affairs shall represent the Association in all matters pertaining to all veterans.

(O) The Committee on Constitution and By-Laws shall recommend to the House of Delegates any amendments which seem to be necessary or advisable. Proposed amendments shall be referred to this committee before action is taken by the House of Delegates.

(P) The Committee on Awards shall have complete charge of all awards made by the Association or in the name of the Association. The decisions of this Committee shall be final in reference to recipients.

(Q) The Committee on the Woman's Auxiliary shall cooperate with, advise and direct the Auxiliary in all matters concerning the Association.

(R) The Committee on Hospitals shall pursue a continuing study of the relation of the medical profession to the operation of public and voluntary hospitals within this State and, shall, when indicated, confer with the State Department of Health, the Georgia Hospital Association and all related organizations and make recommendations to the Association.

Will Read:

CHAPTER IX.

Standing Committees

SEC. 1. The Standing Committees of the Association shall be as follows:

- (A) Committee on Legislation
- (B) Committee on Medical Education
- (C) Committee on Medical Defense
- (D) Committee on Professional Conduct
- (E) Committee on History and Vital Statistics
- (F) Committee on Public Health
- (G) Committee on Maternal and Infant Welfare
- (H) Committee on Rural Health
- (I) Committee on Industrial Health
- (J) Committee on Public Service
- (K) Committee on Cancer
- (L) Committee on Insurance and Economics
- (M) Committee on Veterans' Affairs
- (N) Committee on Constitution and By-Laws
- (O) Committee on Scientific Exhibit Awards
- (P) Committee on Woman's Auxiliary
- (Q) Committee on Hospital Relations
- (R) Committee on Crawford W. Long Memorial
- (S) Committee on Mental Health
- (T) Committee on Geriatrics

SEC. 2. Unless otherwise provided in these By-Laws, each of these committees shall consist of three members, each of whom shall serve for three years. Unless otherwise provided in these By-Laws, Executive Committee of Council shall appoint standing committee members and standing committee chairmen as needed. One member of each standing committee shall be appointed each year by the Executive Committee of Council to serve for three years. The Executive Committee shall make all appointments at least 30 days prior to the Annual Session and all standing committees shall hold their organizational meetings at the time of the year. The President, with the approval of Council, may replace any member of any committee who fails to show interest in performing the committee duties assigned him. All committee chairmen shall make an annual report in writing to the Association headquarters office sixty days in advance of the annual session for consideration by the House of Delegates.

(A) Proposed complete deletion.

SEC. 3 (A). COMMITTEE ON LEGISLATION. The Committee on Legislation shall be composed of a chairman who shall have charge of matters pertaining to State of Georgia legislation; a vice-chairman, who shall have charge of matters pertaining to legislation of the Congress of the United States, and three other members. The chairmen of the following committees, shall serve as ex-officio members without the right to vote: Medical Education, Public Health, Maternal and Infant Welfare, Rural Health, Industrial Health, Insurance and Economics, Veterans' Affairs, Hospital Relations and Mental Health. The President of the State Board of Medical Examiners and the Chairman of the State Board of Health shall also be ex-officio members of this committee without the right to vote.

The duties of the committee shall be to represent the Association in securing and enforcing State of Georgia and Federal legislation as directed by Council, in the interests of public health and scientific medicine. The committee shall meet at least sixty days prior to the convened sessions of either the Georgia General Assembly or the Congress of the United States. The committee shall appoint at least ten keymen, one from each congressional district to represent the committee in their area on matters pertaining to legislation of the Congress of the United States. As many other keymen as are needed shall be requested to represent the committee on matters pertaining to State of Georgia legislation.

SEC. 3 (B). COMMITTEE ON MEDICAL EDUCATION. The Committee on Medical Education shall be composed of a chairman and two other members and the deans of the medical schools in the State of Georgia who shall serve in an *ex-officio* capacity without the right to vote. The committee shall consider and devise means of extending the educational work of the Association for the benefit of its members, working with the component societies whenever possible, and serve for the Council on Medical Education of the American Medical Association in this State. The committee shall act as an advisory body in matters concerning medical education as directed by Council. All problems relating to the postgraduate study of medicine shall be referred to this committee.

SEC. 3 (C). COMMITTEE OF MEDICAL DEFENSE. The Committee on Medical Defense shall consist of five members of whom the Chairman of Council Committee on Finance and the Secretary shall be members. The other members, one of whom shall be appointed chairman, shall be appointed by the Executive Committee of Council for terms of five years each. The duties of this committee shall be to investigate any claim of alleged malpractice made against any member upon the written request to the committee by said member. The committee shall, on the advice of Counsel, in cases being worthy of defense, furnish the services of the Association counsel for the purpose of consultation and advice relative to threatened or actual litigation provided the Association does not assume financial obligation in excess of \$100.00 for any one member in any calendar year. Any charges or fees in excess of \$100.00 for any one member in any calendar year shall be borne by the member so requesting the privilege of medical defense consultation and advice as stated herein.

SEC. 3 (F) COMMITTEE ON PUBLIC HEALTH. Committee on Public Health shall be composed of a chairman and a member of the Georgia State Department of Health appointed by the Executive Committee of Council of the Medical Association of Georgia and the chairman of each of the following Association committees: Industrial Health, Rural Health, Hospital Relations, Legislation, Medical Civil Preparedness, Mental Health, Crippled Children, Maternal and Infant Welfare, Geriatrics, Cancer, Insurance and Economics, and Blood Banks. The chairmen of these committees shall then automatically be members of the Association's Public Health Committee and shall select an alternate member from each of their respective committees to represent them at Public Health Committee meetings in the absence of the chairman. It shall be the duty of the Public Health Committee to meet at least annually to hear reports from the Committee chairman members so named, to correlate their activities and to act as a "clearing house" for any matters concerning public health. It shall also be the duty of the Public Health Committee to correlate these activities with the Georgia Department of Public Health.

SEC. 3 (G). COMMITTEE ON MATERNAL AND INFANT WELFARE. The Committee on Maternal and Infant Welfare shall be composed of three or more general practitioners, three or more obstetricians, and three or more pediatricians. Terms of office shall be for a period of three years with one third of the members appointed annually by the Executive Committee of Council. The committee shall regularly review and analyze the causes of all maternal deaths and perinatal losses occurring in the State for the purpose of recommending improvement. It shall also investigate conditions affecting maternal and infant care in Georgia and make recommendations concerning improvements thereof. The committee shall meet a minimum of twice annually.

SEC. 3 (H). COMMITTEE ON RURAL HEALTH. The Committee on Rural Health shall concern itself with improving medical service in the more sparsely settled areas in the State. It shall be composed of one member from each of the Councilor Districts comprising the Association as appointed by the Executive Committee of Council, and in addition, a member of the State Department of Public Health who shall serve as a member

ex-officio without the right to vote. It shall investigate and make recommendations as to locating and staffing health centers and shall cooperate with the Better Health Council of Georgia, and the Council on Rural Health of the American Medical Association.

SEC. 3 (J). COMMITTEE ON PUBLIC SERVICE. The Committee on Public Service shall be appointed by the Executive Committee of Council. It shall be the duty of the committee to integrate and publicize all approved plans and projects emanating from the Council and other standing and special committees of the Association. It shall consider all policies and make suggestions and recommendations for improving or changing such policies for the purpose of integration and publicizing. It shall develop additional projects for bettering understanding between physicians and the public.

SEC. 3 (L). COMMITTEE ON INSURANCE AND ECONOMICS. The Committee on Insurance and Economics shall consist of not less than ten members, one from each Councilor district, to be appointed for a period of three years in rotation by the Executive Committee of Council and the Executive Committee shall appoint one of these chairman. The chairman may nominate lay persons with known interest in the field of insurance for appointment by the Executive Committee to serve in an advisory capacity.

SEC. 3 (O). COMMITTEE ON SCIENTIFIC EXHIBIT AWARDS. The Committee on Scientific Exhibit Awards shall have complete charge of all awards made by the Association or in the name of the Association for scientific exhibitors at the annual session.

SEC. 3 (Q). COMMITTEE ON HOSPITAL RELATIONS. The Committee on Hospital Relations shall pursue a continuing study of the relation of the medical profession to the operation of public and voluntary hospitals within this State and shall, when indicated, confer with the State Department of Health, the Georgia Hospital Association and all related organizations and make recommendations to this Association.

SEC. 3 (R). COMMITTEE ON CRAWFORD W. LONG MEMORIAL. The Committee on Crawford W. Long Memorial shall supervise matters pertaining to the Crawford W. Long Memorial and shall represent the Association in such matters subject to the approval of Council.

SEC. 3 (S). COMMITTEE ON MENTAL HEALTH. The Committee on Mental Health shall promote the welfare of the mentally ill in the State of Georgia and shall constantly seek means of improving care for the mentally ill in the State.

SEC. 3 (T). COMMITTEE ON GERIATRICS. The Committee on Geriatrics shall concern itself with the medical problems of the aged and chronically ill patient and pursue a continuing study of this problem as it affects the public health.

Now Reads:

CHAPTER X.

Special Committees

Special committees may be created at any time when the necessity arises. Their necessity must be approved by the Council and they shall be appointed by the President.

CHAPTER X

Special Committees and Executive Secretary

SEC. 1. SPECIAL COMMITTEES. Special committees may be created at any time when the necessity arises. Their necessity must be approved by the Council and they shall be appointed by the President.

SEC. 2. EXECUTIVE SECRETARY. The Executive Secretary shall be the administrative agent of this Association, of its Council and of all its committees. He shall be the executive agent of the Association transacting its business under the direction of the Executive Committee of Council and shall be the directing manager of the Headquarters Office. He shall discharge the administrative functions of the Association not within the duties of the Association officers and committees and shall keep himself informed in regard to non-professional matters affecting the medical profession. He shall be responsible to the Executive Committee of Council for the execution and carrying out of the policies of the Association and in that connection shall perform all specific tasks committed to him by the committees, the Council and the officers of this Association.

The selection, terms of employment and salary of the Executive Secretary shall be determined by the Executive Committee of Council, subject to the approval of Council. The Executive Secretary shall be responsible to the Executive Committee of Council and the Executive Secretary shall prepare a report on the activity and status of the Headquarters Office for the Executive Committee of Council at each of their meetings to keep the committee informed at all times.

Now Reads:

CHAPTER XI.

The Journal

Sec. 1. The Journal of the Medical Association of Georgia herein referred to as The Journal, shall be under the control and direction of the Council. It shall appoint an Editor, and an Editorial Board and make any other provisions for the publication of The Journal which in its judgment are necessary. Such appointee or appointees shall serve at the pleasure of the Council, which shall have full discretionary power to promulgate rules and regulations governing the publication of The Journal; enumerate and define the powers and duties of the Editor or Editorial Board, or both; and fix the terms and conditions of their appointment.

Will Read:

CHAPTER XI.

The Journal

SEC. 1. THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA herein referred to as THE JOURNAL, shall be under the control and direction of the Council. It shall appoint an Editor and an Editorial Board annually and make any other provisions for the publication of THE JOURNAL; enumerate and define the powers and duties of the Editor or Editorial Board, or both; and fix the terms and conditions of their appointment.

SEC. 4. The Executive Committee of the Council shall constitute the Publications Committee of THE JOURNAL.

Now Reads:

CHAPTER XII.

Rules and Ethics

Sec. 1. The Principles of Ethics of the American Medical Association shall govern the members of this Association.

Will Read:

CHAPTER XII

Rules and Ethics

SEC. 1. The Principles of Ethics of the American Medical Association, this Constitution and By-Laws as now set forth or as may be hereafter amended and the standards of the profession in Georgia shall govern the conduct of the members of this Association.

Now Reads:

STANDING RULES

1. The Committee on Scientific Work shall prepare the program for all scientific meetings of the Association at all Annual Sessions. It may divide the scientific work into whatever number of sections that seem advisable for the particular Annual Session. It shall appoint temporary officers for all sections until such time as the sections apparently become permanent. As each section becomes established it shall elect its own officers to such rules and regulations as may be laid down by the Committee on Scientific Work. The program for all general meetings shall be prepared by the Committee itself. In its work the Committee shall be subject to the approval of the Council and, when necessary, to the House of Delegates.

2. The Executive Committee of the Council shall constitute the Publications Committee of The Journal.

Will Read:

STANDING RULES

Proposed complete deletion.

New Members

Name	Address	Classification	County
Carl L. Anderson	830 Mulberry St., Macon	Associate	Bibb
Franklyn P. Bousquet	115 E. Jones St., Savannah	Active	Ga. Med.
Gabriel Alexis P. D'Amato	228 E. Huntingdon St., Savannah	Active	Ga. Med.
Lamont Earl Danzig	125 E. Jones St., Savannah	Active	Ga. Med.
Hampton Lee Schofield, Jr.	202 E. Hall St., Savannah	Active	Ga. Med.
Richard Arnold Silver	Memorial Hospital of Chatham County, Savannah	Active	Ga. Med.
Robert P. Coggins	1205 Roswell St., Marietta	Active	Cobb
Hugh S. Colquitt	Smyrna	Associate	Cobb
James Hunt Manning	206 Roswell St., Marietta	Active	Cobb
Noah D. Meadows	317 Atlanta St., Marietta	Active	Cobb
Joseph Manson Scott	Paulding County Hospital, Dallas	Active	Cobb
Cecil H. Blackburn	457 Candler Rd., S.E., Decatur	Active	DeKalb
L. M. Vinton, Jr.	459 Candler Road, Decatur	Active	DeKalb
Leslie Marvin Buckner	1009 N. Monroe St., Albany	Active	Dougherty
Larry R. Cauthen	Floyd Hospital, Rome	Active	Floyd
John Henry Gross	Batley State Hospital, Rome	Active	Floyd
John Leonard Shek	Batley State Hospital, Rome	Active	Floyd
William G. Avery	1293 Peachtree St., N. E., Atlanta 9	Active	Fulton
Henry J. Climo	340 Boulevard, N. E., Atlanta 12	Active	Fulton
John J. Gerling	Surfside Apt. 6, Isle of Palms, S. C.	Associate	Fulton
Lewis B. Hasty	552 W. Peachtree St., N. W., Atlanta 8	Associate	Fulton
Dorothy S. Jaeger Lee	3825 Wieuca Road, N. E., Atlanta 5	Active	Fulton
William W. Moore, Jr.	Hilsman Hospital, Birmingham, Ala.	Associate	Fulton
William A. Paris	1225 Glenwood Ave., S. E., Atlanta 16	Active	Fulton
Ralph Waldo Powell	Robert Winship Clinic, Emory University	Associate	Fulton
Charles L. Whisnant, Jr.	762 Cypress St., N. E., Atlanta 8	Active	Fulton
Joseph A. Wilber	69 Butler St., S. E., Atlanta 3	Associate	Fulton
J. W. Pilcher	211 E. 7th St., Louisville	Active	Jefferson
Frank Louis Beckel	St. Francis Hospital, Columbus	Active	Muscogee
Forrest L. Cosby	Martin Bldg., Columbus	Active	Muscogee
Harold G. Jarrell	1123 4th Ave., Columbus	Active	Muscogee
Allen P. Petway	1340 4th Ave., Columbus	Active	Muscogee
Walter G. Thwaite	416 12th St., Columbus	Active	Muscogee
Ralph E. Tiller	1428 13th Ave., Columbus	Active	Muscogee
Wray J. Tomlinson	City Hospital, Columbus	Active	Muscogee
George S. Whatley	1316 13th Ave., Columbus	Active	Muscogee
Lionel Meredith Yoe	1509 Fourth Ave., Columbus	Active	Muscogee
J. W. Purcell, Jr.	Covington	Active	Newton
William Edward Bellamy	Medical Arts Bldg., Augusta	Active	Richmond
Robert D. Waller	VA Hospital, Forest Hills Div., Augusta	Associate	Richmond
Ohlen Rudolph Wilson	Alma	Active	Ware
Richard L. Benson	219 N. Pentz St., Dalton	Active	Whitfield
Paul Bernard Reaser	310 W. Paugh, Dalton	Active	Whitfield

ANNOUNCEMENTS

Specialty Societies of the State of Georgia

- 1—*Anesthesiologists, Georgia Society of*—May 13-14, Atlanta Biltmore Hotel; October meeting undecided.
- 2—*Chest Physicians, Georgia Chapter, American College of*—May 13-14, Atlanta Biltmore Hotel.
- 3—*Diabetic, Georgia Association*—May 14, Atlanta Biltmore Hotel.
- 4—*General Practice, Georgia Academy of*—October 17-18, General Oglethorpe Hotel, Savannah.
- 5—*Heart, Georgia Association*—September 14-15, General Oglethorpe Hotel, Savannah
- 6—*Industrial Surgeons, Georgia Association*—May 14, Atlanta Biltmore Hotel
- 7—*Obstetrical and Gynecological, Georgia State Society*—May 14, Atlanta Biltmore Hotel; October meeting undecided.
- 8—*Orthopedic, Georgia Association*—May 13-14, Atlanta Biltmore Hotel; September 22-23, King and Prince Hotel, St. Simons Island.
- 10—*Pathologists, Georgia Association of*—May 15, Atlanta Biltmore Hotel; November meeting to be decided at May meeting
- 11—*Pediatric, Georgia Society*—May 13, Atlanta Biltmore Hotel; October 26, Atlanta
- 12—*Physicians, American College of*—(this is a Southeastern society and there is not a Georgia chapter)
- 13—*Radiological, Georgia Society*—May 13-14, Atlanta Biltmore Hotel; November 19-20, St. Simons Island.
- 14—*Surgeons, Georgia Chapter, American College of*—May 13, Atlanta Athletic Club; September 28-29, King and Prince Hotel, St. Simons Island.
- 15—*Trudeau, Georgia Society*—May 14, Atlanta Biltmore Hotel; September meeting undecided
- 16—*Urological, Georgia Society*—May 14, Atlanta Biltmore Hotel

Georgia Heart Association Annual Award—\$100 for best paper submitted on any subject in cardiovascular field. Competition is limited to

interns, house officers, and fellows in Georgia hospitals; Georgia physicians practicing in Georgia or temporarily on military duty who have been in private practice for not more than five years. No paper shall exceed 7,000 words. All papers become the property of the Georgia Heart Association. Closing date: June 1, 1956. For further information address: Chairman, Awards Committee, Georgia Heart Association, Inc., 318 Western Union Bldg., Atlanta 3, Ga.

Postgraduate course: The Management of Diabetes—University of Colorado School of Medicine, Denver, Colo., May 17-19, 1956. The course will offer a review of basic knowledge of the disease and will orient the physician to the newer developments in the field, stressing the practical applications. For further information, write to the Office of Postgraduate Medical Education, University of Colorado Medical Center, 4200 East Ninth Ave., Denver 20, Colo.

American Cancer Society 3rd National Cancer Conference—Sheraton-Cadillac Hotel, Detroit, Mich., June 4, 5, and 6, 1956. Morning and afternoon sessions will begin with a general session with an outstanding speaker; the general sessions will break into various symposia to discuss cancer of different body sites. Copies of the program and advance registration cards may be obtained from the National Cancer Conferences Coordinator, American Cancer Society, 521 West 57th St., New York 19, N. Y.

Short Course in Pediatric Advances, for Pediatricians and General Practitioners—May 28-June 1, 1956, The Children's Hospital of Philadelphia. A refresher course conducted by the staff of the hospital in collaboration with the Univ. of Pa. and the Camden Municipal Hospital. Tuition—\$100.00.

DEATHS

W. PRUITT ALLEN, Woodbury, died in his sleep on February 29, 1956, at his home in Woodbury. He was 71 years old. Dr. Allen had practiced in Woodbury for the last

40 years, having moved there from Molena. He was a member of the Baptist Church.

Survivors include his wife; a sister, Mrs. Elmo Adams of North Carolina; and two brothers, Mr. Stout Allen, Alabama, and Dr. Suggs Allen, Oxford.

Funeral services were held at the Woodbury Baptist church with burial in the Molena cemetery.

CHARLES COLDING LAWRENCE, Savannah, retired Savannah physician, died on February 27, 1956, in an Atlanta hospital. He was 81 years old at the time of his death.

A native of Atlanta, Dr. Lawrence had practiced medicine in Savannah until his retirement several years ago. He attended the University of Georgia and was graduated from the old Atlanta Medical College in 1895. He was a 50 year member of Alpha Tau Omega. Dr. Lawrence was a member of St. Luke's Episcopal Church in Atlanta.

Graveside services were held on February 29, 1956, at St. James' Episcopal Church, Marietta.

HENRY LAZARUS LEVINGTON, Savannah, died on February 28, 1956, at the age of 62. Dr. Levington was a past president of the Georgia Medical Society.

A native of Savannah, he graduated from the Medical College of Georgia and began his practice of medicine in 1920 after completing his residency at the old Savannah Hospital, now the Warren A. Canfield Hospital.

Dr. Levington was a member of Agudath Achim and B. B. Jacob Synagogues, the Zionist Organization, Jewish Educational Alliance and B'nai B'rith. He was also a member of the Century Club of the University of Georgia and a fellow of the American College of Surgeons.

Dr. Levington is survived by his wife, the former Miss Mary Durant; three brothers, the Messrs. Isaac, Joseph and Abram Levington; and one sister, Mrs. Henry Zerman.

Funeral services were held on February 29th; burial was in Bonaventure Cemetery. Members of the Georgia Medical Society were honorary pallbearers.

CHARLES EDWARD WILLS, Washington, died on March 4, 1956, from injuries received when he was struck by a truck. The Wilkes County Medical Society has adopted the following resolution on his death:

(Deaths)

"The death of Dr. Charles E. Wills has brought sorrow to a host of people who loved, trusted, and admired him, and it will be difficult to fill the place he has so ably and efficiently filled in Wilkes County.

"Charles Edward Wills was born in Danielsville, Madison County, Georgia, on December 13, 1891, the son of Dr. Thomas J. Wills and his wife Susie Wingfield. His father practiced medicine in Madison county and later moved to Washington when Edward was a child, and he is remembered as a courteous gentleman, a well rounded, successful doctor and a highly respected and loved citizen. His mother was the daughter of Judge Charles Wingfield and a member of an old line Wilkes county family, her father being a prominent planter and business man.

"After attending Washington Public School he entered Mercer University at Macon where he graduated in 1912. He took part in athletics and was an enthusiastic and efficient baseball player.

"Upon graduating from Mercer he entered the medical department of Columbia University in New York and received his M.D. degree from that institution in 1916. He served as interne in Post Graduate Hospital and had just finished his internship when the United States became engaged in the First World War. He entered the medical corps of the Army and was stationed at Camp Gordon in Atlanta, Georgia, serving in the hospital there for two years as chief of the surgical staff in urology. When discharged from the army at the close of the war he came home to Washington to practice his chosen profession. He entered into a partnership with Dr. A. W. Simpson, Sr. and the firm of Simpson & Wills continued for a long term of years.

"In 1920 he married Miss Frances Wright of Auburn N. Y., whom he met while she was a nurse during the war. He brought her home to Washington and she has been an inspiration and tower of strength to him while in the formative stage of his career and truly a helpmate always.

"Dr. Wills was one of the organizers of the Washington General Hospital and has given of his time and talents to make it the great institution it is today. As superintendent over many years, he displayed great business talents and placed it on an independent financial basis.

"As Dr. Wills has been such an

integral part in all phases of life in this community; and

"As he has labored faithfully and efficiently in alleviating suffering in humanity regardless of race, color, social or financial condition; and

"As he has been a tower of strength in the affairs of the Wilkes County Medical Society and has served it in every official capacity:

"BE IT RESOLVED:

"That Wilkes County has lost a most valued and efficient physician and surgeon; and

"That the Medical Society has lost a guiding personality who was a friend to and a co-worker with each member and whose presence will be missed always; and

"BE IT FURTHER RESOLVED, that a copy of these resolutions be put in the minutes of the Wilkes County Medical Society, a copy be sent to the family of Dr. Wills, and a copy be sent to the *News-Reporter* and the *Journal of the Medical Association of Georgia*."

SOCIETIES

The TENTH DISTRICT MEDICAL SOCIETY held its winter meeting on February 16, 1956, at the Country Club in Athens. Goodloe Y. Erwin presided. A morning session of golf was held for the sports enthusiasts, and an afternoon professional program of three papers followed. John Howard spoke on "Common Injuries to the Eye"; William V. Crosby, "Functional Uterine Bleeding"; and George Erwin, "Accidents in Childhood."

The BARTOW COUNTY MEDICAL SOCIETY held its quarterly meeting on March 7, 1956; Ross Whatley was host for the meeting. Guest speaker was Richard E. Felder, Atlanta, who spoke on "Psychotherapy."

At its meeting on February 13th, the DEKALB COUNTY MEDICAL SOCIETY voted to pass a resolution setting up a scholarship for a student nurse from Decatur or DeKalb County. The scholarship will include tuition for three years at one of the schools of nursing in the Greater Atlanta area.

The GEORGIA MEDICAL SOCIETY met on February 11, 1956, to hear a talk by James J. Waring on "Control of Tuberculosis." Dr. Waring, a former Savannahian, is director of the Colorado Foundation for Research in Tuberculosis. On Febru-

ary 29, the society honored the immediate past president Samuel J. Rosen at the annual Past President's Dinner. James C. Metts was toastmaster. The GEORGIA MEDICAL SOCIETY has again this year sponsored public medical forums. Jules Victor was chairman of arrangements. The subjects for discussion were "Doctor Bills and Hospital Bills," "Emotions and Sickness," "Problem Children," and "Living with Cancer"; they were chosen by public ballot.

The regular monthly meeting of the HABERSHAM COUNTY MEDICAL SOCIETY was held on March 1, 1956, at the Commercial Hotel, Cornelia. After dinner, Harvey Newman, Gainesville, spoke to the members on "Hypo- and Hyper-gammaglobinemia." A roundtable discussion followed his presentation.

The RICHMOND COUNTY MEDICAL SOCIETY met on February 28, 1956, to hear an address by Edward S. Ray, associate professor of medicine at the Medical College of Virginia, on diseases of the chest. This year again, the society is co-sponsoring public medical forums. The first forum was on "Tuberculosis," the second was to have been on "Intestinal Disorders" but had to be called off; and the third and last, on April 29th, will be on "Mental Health."

Officers for this year have been elected by the SCREVEN COUNTY MEDICAL SOCIETY. They are as follows: Katrine Rawls Hawkins, Sylva, president; James Freeman, vice-president; and G. B. Hogsette, secretary-treasurer.

The STEPHENS COUNTY MEDICAL SOCIETY met on January 28, 1956, and elected the following officers to serve in 1956: S. L. Harp, president; M. D. Pittard, vice-president; and C. L. Ayers, secretary.

The WALKER-CATOOSA-DADE MEDICAL SOCIETY met on January 31st to elect officers for 1956. They are: Robert L. Patterson, Chickamauga, president; Thomas E. Adkins, Rossville, president-elect; Fred H. Simon-ton, Chickamauga, and Louis A. Williams, Ringgold, delegates; and E. M. Townsend, Ringgold, secretary and treasurer.

At the March 1st meeting of the WARE COUNTY MEDICAL SOCIETY a kinescope of a closed circuit television program on acute abdominal disorders was shown. The film, prepared by the Upjohn Company, dealt

with diagnosis and management of gangrenous gallbladder, splenic hemorrhage, and duodenal ulcer. At this meeting of the society, Ware County Representative Cleve Mincy was an honor guest; he was praised for "his work in the recent session of the Georgia General Assembly for sponsorship of legislation affecting the medical profession and beneficial to the general health and welfare of the people of Georgia." Another guest at the meeting was Mr. John F. Kiser, assistant executive secretary of the Medical Association of Georgia.

The WAYNE COUNTY MEDICAL SOCIETY met on February 14, 1956, and elected the following officers for 1956: Fred M. Harper, Jesup, president; R. A. Pumpelly, vice-president; Daniel H. G. Glover, secretary and treasurer; Albert R. Howard, program chairman; and J. W. Yeomans and Cecil Jacobs, delegates.

The GEORGIA SOCIETY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY held its annual meeting in Savannah in March. Alton V. Hallum, Atlanta, president, presided. Guest speakers included Irving Henry Leopold, Philadelphia; F. Bruce Fralick, Ann Arbor, Mich.; Frank D. Costenbader, Washington, D. C.; Harry Rosenwasser, New York, N. Y.; Chevalier L. Jackson, Philadelphia, Pa.; and Peter N. Pastore, Richmond, Va. Approximately 100 physicians attended the meeting. New officers elected to serve for a year are as follows: William L. Barton, Macon, president; Phinzy Calhoun, Atlanta, vice-president; and Percy W. Rhyne, Albany, secretary-treasurer. The society will hold its 1957 meeting in April aboard a cruise ship en route from Charleston, S. C., to Nassau.

The tenth annual meeting of the SOUTHERN SOCIETY OF ANESTHESIOLOGISTS was held in Augusta in March. Edgar R. Pund, president of the Medical College of Georgia, delivered the address of welcome to the three-day meeting. The theme of the convention was "Ten Years Ago and Today"; David A. Davis, professor of anesthesiology at the University of N. C., and president of the society, presided. Alice McNeal, professor of anesthesiology at the Medical College of Alabama, is the incoming president. Guest speakers for the meeting were John Adriani, New Orleans; E. A. Rovenstine, New York City; Ralph Sappenfield, Miami; and Donald Stubbs, Washington, D. C.

PERSONALS

First District

J. M. BYNE, JR., Waynesboro, has been elected to the Board of Directors of Physicians Service, Inc., the Blue Shield Plan with headquarters in Columbus. The election was announced at the annual meeting held in Columbus in January.

ELLISON R. COOK, III, Savannah, addressed the members of the Chat-ham-Savannah Health Council at their quarterly meeting in February. Dr. Cook discussed the work of the State Commission on Alcoholism and described plans for a clinic to help cure alcoholics which is expected to open in Savannah soon.

Dr. and Mrs. WILLIAM R. DANCY, Savannah, were the guests of honor at the "Turn of the Century Ball" in celebration of Doctors' Day of the Georgia Medical Society on March 21st. The doctors and their wives dressed in the mode of the early nineteen hundreds for this party held in the Grand Ballroom of the Hotel DeSoto.

LAMONT E. DANZIG, Savannah, was the speaker at a recent meeting of the Vidalia Parent-Teacher Association.

ALBERT M. DEAL, Statesboro, attended the meeting of the Federation of State Medical Boards of the United States representing the State of Georgia as president of the State Board of Medical Examiners.

E. CARSON DEMMOND, Savannah, has been elected president of the Savannah Rotary Club; he will take office on July 1st. Dr. Demmond has been a member of the club since 1938. Other offices that Dr. Demmond has held include the presidency of the Georgia Medical Society, First District Medical Society, Savannah Health Center, and Hospital Service Association; and he is a former medical director of Telfair Hospital. Dr. Demmond has just recently been made a director of the Hospital Service Association of Savannah, Inc.

ROBERT B. GOTTSCHALK, Savannah, has been elected president of the Medical Arts Center, Inc. JULES VICTOR, Savannah, was elected to serve as vice-president, and the following physicians were named to the Board of Governors: J. HARRY DUNCAN, GRANT W. GOLDENSTAR, DAVID ROBINSON, W. LAWRENCE SALTER, M. M.

SCHNEIDER, HAROLD M. SMITH, JOHN G. ZIRKLE, DR. GOTTSCHALK, and DR. VICTOR.

LAWRENCE LEE, JR., Savannah, has been elected president of the Chat-ham-Savannah Tuberculosis and Health Association. At the meeting held on March 9, 1956, JOHN H. VENABLE, Assistant Director of the State Health Department, was the principal speaker. Newly elected members of the Board of Directors include THOMAS A. MCGOLDRICK, JR., JEFF J. HOLLOMAN, and JOHN B. RABUN.

The *Journal*, on behalf of all the members of the Association, extends to THOMAS A. MCGOLDRICK, JR., Savannah, sympathy on the death of his father, Thomas A. McGoldrick, Sr., M.D., in Brooklyn, N. Y., on March 8, 1956. Dr. McGoldrick was a former professor of medicine at Long Island College of Medicine. He had served as president of the New York State Medical Association and as a vice-president of the American Medical Association. He had practiced in New York for 60 years before retiring two years ago.

Second District

E. E. MOSELEY, Donalsonville, announces the association of Brown Hill Boswell with the staff of the Moseley Hospital and Clinic. Dr. Boswell is a native of Montgomery, Ala., and was educated at the University of Alabama and Tulane University School of Medicine. He practiced medicine in Montgomery for three years and has recently completed a tour of duty with the U. S. Army.

LAURIER E. HACKETT, Camilla, a member of the Board of Directors of Physicians Service, Inc., attended the annual meeting of the board in Columbus in January.

CHARLES D. HOLLIS, JR., and THOMAS D. JOHNSON, Albany, have been certified by the American Board of Internal Medicine. Both physicians are graduates of Emory University and Emory University School of Medicine. They interned at Emory and Grady Memorial Hospitals in Atlanta. Dr. Johnson was a resident and a fellow in cardiology at Emory before coming to Albany; Dr. Hollis served his residency at Minnesota's University Veterans' Hospital and was a fellow in cardiology at Emory before coming to Albany to practice. They both served two years in Germany with the Army Medical Corps. They are now asso-

ciated in the practice of internal medicine in Albany.

LEIGHTON A. SMITH, Quitman, addressed the Hannah Clarke Chapter of the D. A. R. at a recent meeting in Quitman. He talked to the members about socialized medicine.

ERNEST F. WAHL, Thomasville, was the speaker at a recent meeting of the Mothers-Teachers Club of the Central Elementary School in Thomasville. The topic of Dr. Wahl's talk was "Your Part in Prevention of Rheumatic Fever"; he spoke in cooperation with the Rheumatic Fever Prevention program sponsored jointly by the County 4-H Council and the County Home Demonstration Council. Dr. Wahl was also a recent guest speaker at a meeting of the Cairo Kiwanis Club. He devoted the major part of his time to a description of the more common heart diseases and their basic causes and then conducted a question-and-answer period. Dr. Wahl was introduced by C. K. SINGLETON, Cairo, program chairman.

Third District

A new doctors building has recently been completed on Center Street between 7th and 8th Avenues in Columbus. Physicians who will occupy the building are BESSIE MAE BEACH, HAYWOOD H. TURNER, JOHN K. DAVIDSON, III, A. B. CONGER, HARRY H. BRILL, JR., JACK HIRSCH, IVAN R. ELDER, FLOYD C. JARRELL, JR., EDGAR B. HORN, HAROLD G. JARRELL, POLK S. LAND, LEON LAPIDES, S. A. RODDENBERRY, GEORGE SCHUESSLER, JOSEPH C. SERRATO, W. R. SNELLING, and W. P. JORDAN, SR.

J. A. BUSSELL, Rochelle, on February 3rd celebrated his 83rd birthday. He was born in Dooly County in 1873 and graduated from the Atlanta Medical College in 1893. After three years preceptorship under the late Dr. Mitchell of Pineview, Dr. Bussell set up an office in Rochelle where he has resided for the past 60 years. Dr. Bussell says that he is trying to retire but he continues to receive calls.

J. C. LOGAN, Plains, is to be congratulated on being mayor of the town winning top place in the annual Better Home Town contest sponsored by the Georgia Power Company for 1955. Dr. Logan has practiced medicine in Sumter County for 54 years, and has been mayor of

Plains for two years—and he looks forward to progress in both fields.

ROBERT C. PENDERGRASS, Americus, gave a talk on cancer control at a recent meeting of the Americus Lions Club. Following his talk, two movies, "Man Alive" and "The Georgia Crusade Against Cancer," were shown. Dr. Pendergrass is a member of the Board of Directors of the Georgia Division of the American Cancer Society.

At a meeting of the Ben Hill-Irwin County Registered Nurses Association, RALPH D. ROBERTS, Fitzgerald, presented the program consisting of two films, "The Warning Shadow" (concerning lung cancer) and "The Case of an Alcoholic".

CHARLES R. SMITH, Columbus, has been appointed a member of an advisory psychiatric committee for the Mental Hygiene Division of the State Health Department. Dr. Smith attended Hardin-Simmons University and Texas Tech. He received his M.D. degree from the University of Texas Medical School in 1938 and a degree in public health from the University of North Carolina in 1939. He entered private practice in 1946, but from 1948 until 1952 he received psychiatric training at the VA Hospitals in Augusta and Downey, Ill. Since 1952 he has been in the private practice of psychiatry and neurology.

Fourth District

E. T. ARNOLD, JR., Hogansville, addressed the Hogansville Lions Club at a recent meeting, on prevention and treatment of diseases of the heart. In conjunction with his talk a movie of the heart, its functions and diseases, was shown.

The offices of nine physicians in Thomaston were robbed on the same day in February—it was thought that the thief was in search of narcotics, but only money was taken. Those doctors whose offices were broken into are A. A. ARRINGTON, T. A. SAPPINGTON, H. D. TYLER, F. M. WOODALL, PRUITT WOODALL, R. E. DALLAS, W. J. GOWER, and R. J. MINCEY.

GRADY E. BLACK, Griffin, has been certified as a diplomate of the American Board of Pediatrics. Dr. Black is president of the medical staff of the Griffin-Spalding County Hospital this year.

K. S. HUNT, Griffin, has been elected Griffin's "Man of the Year"

by the Griffin Exchange Club. He was one of seven nominated for the honor. Dr. Hunt is a native of Milner; he attended public schools there and the Gordon Institute. He received his M.D. degree from Vanderbilt University. For several years he served as Fourth District Councilor to the MAG.

T. A. SAPPINGTON, Thomaston, has accepted the county commissioners' appointment as county physician and clinician of Upson County. He will fill the vacancy created by the death of J. M. MCKENZIE who had served in that capacity for more than 30 years.

Fifth District

OSLER A. ABBOTT, Emory University, was guest of honor at a recent meeting of the Rome Shrine Club. Dr. Abbott showed a movie of the latest techniques in heart surgery. Members of the Floyd County Medical Society and the staff of Battey Hospital were special guests at the meeting.

WALTER L. BLOOM, Atlanta, was a speaker at the recent meeting of the Southeastern Clinical Club held in Atlanta. Other speakers included EUGENE B. FERRIS, JOHN HOWARD, and ALBERT BRUST, all of Emory University.

WINSTON E. BURDINE, Atlanta, presented a program on mental health at the February meeting of the Woman's Auxiliary to the Upson County Medical Society. In his talk, Dr. Burdine discussed contributing factors in mental illness from infancy through adulthood and the different methods employed by psychiatrists to rehabilitate those who seek their help.

T. STERLING CLAIBORNE, Atlanta, was guest speaker at a meeting of the Monroe Lions Club; his topic was "Rheumatic Fever and Diseases of the Heart". Dr. Claiborne is Chief of the Giddings Memorial Cardiac Clinic at St. Joseph's Infirmary.

Members of the advisory committee of the Fulton County Unit of the American Cancer Society took part in cancer forums held throughout the Atlanta area in conjunction with the showing of a film on breast self-examination. Those participating included the following physicians: A. J. CRUMBLY, L. S. KING, JOHN N. MCCLURE, W. P. NICOLSON, JR., LEA RICHMOND, R. C. HACKNEY, R. A. BILLINGS, W. W. COPPEDGE,

(Personals)

CHARLES S. JONES, DUNCAN SHEPARD, IRVIN BLUMENTHAL, NEIL G. PERKINSON, and MILTON F. BRYANT, JR.

A portrait of DANIEL C. ELKIN, formerly chairman of the department of surgery and Whitehead professor of surgery at Emory University School of Medicine, was presented to Emory at a tea honoring Dr. Elkin on March 8th. F. PHINIZY CALHOUN, Atlanta, was the speaker at this tea, which was attended by officials of the Whitehead Foundation, surgery professors, and other university and medical personnel. Dr. Elkin has made his home in Lancaster, Ky., since his retirement from Emory last year after more than 30 years on the Emory faculty.

VERNELLE FOX, Atlanta, has been named physician-in-charge of the state-owned Georgian Clinic. The clinic, located at 1260 Briarcliff Rd., N. E., Atlanta, is devoted to the treatment of alcoholics. Dr. Fox succeeds GEORGE BACHMANN in this office. She is a graduate of the Tulane University Medical School and was formerly assistant chief of the department of medicine at St. Elizabeth's Hospital in Washington. She has been in practice in Atlanta for three years.

A. HAMBLIN LETTON, Atlanta, attended the recent meeting of the Southeastern Surgical Congress.

R. M. MARTIN, JR., Conyers, has been made a member of the Rockdale County School Board. He was elected to serve by the Superior Court judges of the Stone Mountain District.

Mr. and Mrs. Paul Olds Turner have announced the marriage of their sister, Grace Freeman Surratt, to BOMAR AMOS OLDS, College Park, on Saturday, March 10, 1956, at the Peachtree Christian Church in Atlanta. Dr. and Mrs. Olds are at home at 408 West Virginia Avenue, College Park.

ELEANOR B. PETRIE, Decatur, was the speaker for the public discussion on School Health held on March 1st in Covington. Dr. Petrie is head of the DeKalb County Public Health Service.

JEFF L. RICHARDSON, Atlanta, spoke to the Douglasville Elementary School Parent-Teacher Association at a recent meeting. His topic was rheu-

matic fever, its recognition and treatment, and the state-wide program of the Georgia Heart Association to stop rheumatic fever".

Sixth District

H. DAWSON ALLEN, JR., Milledgeville, was the speaker at the January meeting of the Nancy Hart Chapter, Daughters of the American Revolution, in Milledgeville. Dr. Allen's talk dealt with physicians, their opinions and influence.

L. A. BAILEY, Milledgeville, has closed his office for an indefinite period it has been announced. Dr. Bailey has been associated with Scott Hospital since opening his practice in Milledgeville 20 years ago.

The newly formed Macon Obstetrical Society, Inc., has been granted a charter by the Bibb County Superior Court; according to the charter the organization will operate on a non-profit basis to promote education and educational projects and will aid students in acquiring educations. Petitioners are EDMUND A. BRANNEN, ROLAND A. BROWN, LEON J. GOODMAN, RICHARD L. HANBERRY, JR., WILLIAM K. JORDAN, J. LON KING, JR., JULE C. NEAL, JR., T. E. ROGERS, JR., WILLIAM C. SHIRLEY, EVELYN SWILLING, and O. R. THOMPSON.

R. FRANK CARY, Macon, will retire from the office as health officer of the Macon-Bibb County Health Department on July 1, 1956, it has been announced. Dr. Cary was scheduled to step down on March 1 but a waiver was granted to allow him to continue in office till the later date. Dr. Cary has been health officer for 15 years.

MARVIN L. GREENE, Monticello, showed the Monticello Kiwanis Club slides and commented on his trip to Europe last fall at a meeting held in January. The purpose of his trip was to attend the session of the World Medical Association in Vienna, but he took side trips to Portugal, Spain, France, Austria, Monaco, Italy, and England.

E. M. LANCASTER, Shady Dale, was recently honored at a tea given by the Order of the Eastern Star. Dr. Lancaster, who is grand sentinel of the grand chapter of the order, was presented with a brief case.

GEORGE S. PILCHER, Louisville, is general chairman of the Red Cross Drive in Jefferson County this year.

C. H. RICHARDSON, SR., Macon, has been re-elected president of the non-profit Central Georgia Hospital Service, Inc. Directors elected at the annual meeting in February include J. D. APPLEWHITE, Macon; C. P. SAVAGE and THOMAS M. ADAMS, Montezuma; and JOHN A. BELL, JR., Dublin.

WILBUR M. SCOTT, Milledgeville, has announced that CURTIS F. VEAL, Milledgeville, has joined the staff of Scott Hospital. Dr. Veal will continue to maintain his office in Ennis Heights in addition to assuming his duties in association with the hospital.

Seventh District

J. E. BILLINGS, Calhoun, has been elected president of the Calhoun Rotary Club; he will take office in July of this year. Dr. Billings is a native of North Carolina and a graduate of Berea College in Kentucky. He received his M.D. degree from the Medical College of Georgia and interned at Georgia Baptist Hospital, Atlanta. Dr. Billings practiced general medicine from 1933 until 1955 when he was forced by poor health to give up his active practice. He is a past chief of the medical staff of Gordon County Hospital and a past president of the Gordon County Medical Society.

F. T. FRALICK, Rome, has resigned as senior staff physician at Battey State Hospital in Rome to become director of TB Control of the Fulton County Health Department. He will be succeeded by Paul S. Kemp of Falls Church, Va. Dr. Kemp is a graduate of the Medical College of Georgia and has been in private practice in Falls Church for the past 10 years. GEORGE E. PERKINS, II, has resigned to become director of the Floyd County Health Department.

RALPH B. MCCORD, has been named chairman of the newly organized Abilities of the Blind, Inc., which plans to establish a mattress-making factory in Rome. T. H. MOSS, also of Rome, is vice-chairman. The non-profit corporation is now conducting a fund-raising campaign to raise the \$50,000 necessary to get the factory into operation on a sound financial basis.

The Oakdale Clinic, Smyrna, Cobb County's newest medical center, opened its doors to the public on February 22, 1956, in a new modern brick building at the corner of Oak-

dale and South Atlanta Roads. The staff of the clinic consists of R. PARKS PARNELL, JR., Smyrna, J. C. TANNER, Atlanta, a receptionist and a nurse.

J. H. PRITCHETT, JR., Bremen, spoke to the Bremen Lions Club recently on the work that is now being done in the diagnosis and treatment of the diseases of the heart. Dr. Pritchett is chairman of the Committee on Public Education of the Georgia Heart Association.

ALBERT R. HOWARD, Jesup, has moved his office to the Chaneldo Apartments in Jesup. He has been with the Leaphart Hospital since July 1955, but will carry on his practice in the new location from now on. As was reported in the February issue of this journal, Dr. Leaphart has closed his hospital and bought a home at Sea Island.

L. H. SHELLHOUSE, Willacoochee, has retired from the active practice of medicine after having been in practice there for 45 years. Dr. Shellhouse came to Willacoochee from Aiken, S. C., in 1911, and since that time has endeared himself to the people of the community as a man of high civic, moral and religious principles—a trusted physician and friend.

The *Journal* wishes to express to NEAL F. YEOMANS, Waycross, and JAMES W. YEOMANS, Jesup, the sympathy of their friends in the Association on the death of their father, Mr. Bryant Lester Yeomans, Sr., of Jesup, on February 27, 1956.

Ninth District

RAFE BANKS, JR., and W. PERRIN NICOLSON, III, Gainesville, announce the removal of their offices to 930 Vine Street, Gainesville. Their former address was 111 North Main Street.

Dr. and Mrs. COURTNEY C. BROOKS, Blue Ridge, announce the birth of a son, Courtney C. Jr., on February 2, 1956.

ROBERT T. CAIN, formerly of Clayton, announces the opening of his office at the corner of Sycamore and East Spring Streets in Gainesville for the practice of general medicine. An associate, C. J. Walker, Jr., who is serving with the Army at Fort Benning, will join him in Gainesville in July. Dr. Cain is a native of South Dakota; he attended the Uni-

versity of Michigan and graduated from Emory University and the Emory University School of Medicine. He interned at Brooke General Hospital, San Antonio, Texas. Dr. Cain practiced in Clayton for two years immediately before going to Gainesville.

JOHN CAUBLE, formerly of Atlanta, is now associated with WILLIAM H. NICHOLS, Canton, in the practice of general medicine. A native of Austell, Dr. Cauble graduated from Emory University School of Medicine and interned at Piedmont Hospital and Crawford W. Long Hospital in Atlanta.

RALPH H. CHANEY, JR., Augusta, is now living in Toccoa. A graduate of the University of Pennsylvania, Dr. Chaney is now associated in practice with W. BRUCE SCHAEFER and M. D. PITTARD.

BRADLEY B. DAVIS, Gainesville, has announced his retirement from the active practice of pediatrics in Gainesville as of the 1st of April.

GUY O. EVERHART, Loganville, has been named by the stockholders as a member of the Board of Directors of the United American Life Insurance Company. At a subsequent meeting, Dr. Everhart was appointed to serve as the company's medical director. A graduate of Wofford College, Dr. Everhart received his M.D. degree from the Medical College of South Carolina and has been in practice in Walton County for two years.

Dr. and Mrs. F. OLAND GARRISON, Demorest, announce the birth of a daughter, Sandra Celeste, on January 16, 1956.

SAMUEL H. HAY, Toccoa, has been certified by the American Board of Internal Medicine. A native of North Carolina, Dr. Hay graduated from Harvard Medical School and received three years of graduate training in internal medicine at the University of Virginia Hospital. Since his arrival in Toccoa in October 1953, he has been a member of the staff of the Toccoa Clinic and has served as a consultant in medicine at the Habersham and Rabun County Hospitals.

Dr. and Mrs. L. G. HICKS, JR., Clarkesville, announce the birth of a daughter, Flora Argen, on February 25, 1956.

F. M. McELHANNON, Winder, will enter a surgical residency at Thayer

General Hospital, Vanderbilt Group, Nashville, Tenn., on the 1st of July.

A. A. ROGERS, Commerce, has been elected chairman of the City Board of Health by the mayor and city council of Commerce.

R. LEE ROGERS, Gainesville, is a candidate for membership on the Board of Roads and Revenue of Hall County. Dr. Rogers is a native of Hall County and a graduate of North Georgia College and Emory University School of Medicine. He is a Civitan, Mason, Shriner, a member of the First Methodist Church, and a former member of the Hall County Board of Health and the Georgia Democratic Executive Committee. He is chairman of the State Board of Health, an office he has held for 12 years, having served on the board for five years prior to becoming chairman. This is Dr. Rogers' first attempt at gaining election to a public office.

ALEX B. RUSSELL, Winder, announces the removal of his office to a new location on Park Avenue. His office was formerly in the Peoples Bank.

The Association extends deepest sympathy to ARTHUR G. SINGER, Toccoa, and his family on the death of his wife.

PAUL P. WESTFALL, Dawsonville, has left his former location and moved to Rahway, N. J.

Tenth District

JAMES W. BENNETT, Augusta, was the speaker at a recent regular meeting of the Parents Association of the Episcopal Day School. His subject was "Accident Prevention with Children"; he used both slides and statistics to illustrate his talk. Dr. Bennett stated that the three things parents should use to prevent children's accidents are forethought, supervision, and discipline.

GEORGE A. BILLINGHURST, formerly of Macon, has announced the opening of an office for the practice of general medicine at 1142 Druid Park Avenue, Augusta. A native of LaGrange, Dr. Billinghurst received his premedical education at Mercer University and his M.D. degree from the Medical College of Georgia.

ALVA H. FAULKNER, Augusta, was the guest speaker at the American Business Women's Association at a meeting held in March.

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Journal OF THE MEDICAL ASSOCIATION OF GEORGIA

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W. Bruce Schaefer, M.D.

President-Elect, 1956-1957

W. BRUCE SCHAEFER, M.D., is the new president-elect of the Medical Association of Georgia, having been elected by acclamation to serve in that capacity for the year 1956-1957. Dr. Schaefer's election to this office, in preparation for the highest office in the Association, climaxes years of diligent work and faithful service to the Medical Association of Georgia, and, rather than being a reward for past service, it is an affirmation of the faith the Association has in his loyalty and ability to carry out the duties of the office of president.

William Bruce Schaefer was born in Toccoa on January 7, 1908. He received his undergraduate education at Clemson College in South Carolina and graduated from Emory University School of Medicine in 1930. After interning at Maryland General Hospital, Baltimore, he was assistant resident and resident surgeon in the Baltimore City Hospitals for two years.

Since 1933, when Dr. Schaefer returned to Toccoa to practice general surgery, the name Bruce Schaefer has become an exceedingly well known and respected one in medical and civic circles, not only in Toccoa but throughout Georgia and the Piedmont.

Dr. Schaefer is a member and past president of the Stephens County Medical Society and of the

Ninth District Medical Society. He is also a member of the American Medical Association and the Southern Medical Association, and a fellow of the American College of Surgeons and the International College of Surgeons. In 1953, he was president of the Piedmont Postgraduate Medical Assembly.

In addition to his active medical practice, Dr. Schaefer has found time to participate in many community activities. He is a member of the Masonic Order; the Benevolent Protective Order of Elks; Toccoa Kiwanis Club, of which he is vice-president; and the Toccoa Country Club, of which he is president. He is a member of the Gridiron Society of the University of Georgia, Alpha Kappa Kappa medical fraternity, and Delta Tau Delta social fraternity.

Dr. Schaefer is a director of the Citizens Bank of Toccoa and a member of the Toccoa Board of Education. He has served on the Toccoa City Government Commission and was mayor of the city in 1948. He is also a deacon of the Toccoa Presbyterian Church.

From November 1940 to January 1945, he served with the United States Army Medical Corps.

Mrs. Schaefer, the former Miss Orville Tyler, is also well known as a leader in civic affairs. She is president of the Better Health Council of Georgia and was chairman of the Woman's Division of the Georgians for George before Senator Walter F. George decided to withdraw his name as a candidate for re-election to the United States Senate.

Dr. and Mrs. Schaefer have two children: a son, Bruce Jr., who is a student at Clemson College, and a daughter, Tyler, a student in the upper school of the Westminster Schools, Atlanta.

Dr. Schaefer has served on the Council of the Medical Association for seven years and as chairman of the Council Committee on Audit and Appropriations. His election by acclamation to the office of president-elect indicates clearly that he has won the respect and admiration of not only the officers, councilors, and staff of the Medical Association of Georgia, but of all of the members. Congratulations are in order, and they are freely given to W. Bruce Schaefer, M.D., President-Elect of the Medical Association of Georgia, 1956-1957.

Registration

In attendance at the 106th Annual Session of the Medical Association of Georgia, May 13-16, 1956, Atlanta Biltmore Hotel, Atlanta, Georgia, were: 912 MAG member physicians; 132 non-member physicians including residents, interns and out-of-state guests; 125 guests, including medical students; and 22 non-medical guests. Registered and participating

in the 1st Session of the MAG House of Delegates were 119 delegates and in attendance at the 2nd Session of the House of Delegates were 103 delegates.

Scientific Sessions

Scheduled on the program were 14 scientific section meetings at which 63 papers were presented. Presentations were made by 16 out-of-state guest speakers and 33 Georgia guest speakers. Other presentations of note were the G. P. Day panel discussions on Theology-and-Medicine and Law-and-Medicine and the Floyd W. McRae Lectureship. Papers presented at the session will be published as space permits in the *Journal of the Medical Association of Georgia*.

MAG General Sessions

Two General Sessions were convened. The first featured addresses by the MAG president and the AMA president-elect. Nominations were offered for MAG offices, and because there was no opposition to a *single* nomination made for each office the Secretary was instructed to cast a unanimous ballot for the membership for all physicians nominated. This dispensed with the usual general balloting, and physicians were elected to the following offices:

President-Elect—W. Bruce Schaefer, Toccoa

1st Vice-President—Carl C. Aven, Atlanta

2nd Vice-President—Bernard P. Wolff, Atlanta

AMA Delegate (1957-59)—Spencer A. Kirkland, Atlanta

AMA Alternate Delegate (1957-59)—Henry H. Tift, Macon

AMA Delegate (1957-59)—Eustace A. Allen, Atlanta

AMA Alternate Delegate (1957-59)—William R. Dancy, Savannah

5th District Councilor—J. G. McDaniel, Atlanta

5th District Vice-Councilor—Charles S. Jones, Atlanta

6th District Councilor—Henry H. Tift, Macon

6th District Vice-Councilor—George H. Alexander, Forsyth

7th District Councilor—D. Lloyd Wood, Dalton

7th District Vice-Councilor—Ralph W. Fowler, Marietta

8th District Councilor—F. G. Eldridge, Valdosta

8th District Vice-Councilor — James M. Hicks, Brunswick

At the second General Session, 50 year Certificates were presented to the following MAG members:

Carl L. Anderson, Macon (Tulane Medical School)

Guy D. Ayer, Atlanta (Atlanta College of Phys. and Surg.)

H. F. Bent, Midville (Medical College of Georgia)

E. Cleveland Bridges, Donalsonville (Louisville (Ky.) Medical College)

Henry C. Ellis, McDonough (Atlanta School of Medicine)

William P. Ellis, Chipley (Atlanta College of Phys. and Surgs.)

George T. Hendry, Blackshear (Atlanta School of Medicine)

Charles A. Hodges, Dublin (Kentucky Univ. Medical Dept.)

C. H. Pinson, Atlanta (Memphis Hosp. Med. College) (Deceased)

W. W. Pruett, Norcross (Atlanta School of Medicine)

D. S. Reese, Carrollton (Atlanta School of Medicine)

Charles L. Ridley, Sr., Macon (Medical College of Georgia)

O. W. Roberts, Carrollton (Atlanta School of Medicine)

C. E. Stapleton, Statesboro (Medical College of Georgia)

Carl B. Welch, Attapulgus (Atlanta College of Phys. and Surgs.)

George M. White, Rockmart (Atlanta College of Phys. and Surgs.) (Deceased)

Charles O. Williams, West Point (Atlanta College of Phys. and Surgs.)

J. C. Wooldridge, Columbus (Columbia Univ. College of Phys. and Surgs.)

On recommendation of Council the Hardman Award was not presented this year, and nominations received for this award were held for consideration at the 1957 Annual Session. Certificates of Appreciation were awarded to Mrs. Ralph Major, President, Woman's Auxiliary to the MAG; H. Dawson Allen, Jr., President, MAG; F. G. Hodgson, for his work with Crippled Children's Program; Mr. John F. Kiser, Assistant Executive Secretary; Neal F. Yeomans, Councilor, 8th District; and Mark S. Dougherty, Councilor, 5th District. Scientific Exhibit Awards for exhibits at this Annual Session were awarded as follows:

1st Place: "Histerography"—A. C. Richardson, M.D.; George A. Williams, M.D.; and William Bryan, M.D., Atlanta.

2nd Place: "Radiologic Investigation of the Larynx and Pharynx" Brit B. Gay, Jr., M.D., and Joseph Chang, M.D., Emory University.

3rd Place: "Bony Landmarks in Joint Paracentesis"—Arthur M. Puce, M.D.; James Miller, Ph.D.; I. R. Berger, M.D.; and Albert Lansing, Ph.D., Atlanta.

Honorable Mention: "Plastic Surgery for Defects in the Mid-Face"—W. Stewart Flanagan, M.D., Augusta.

"Treatment of Skin Tumors"—R. C. Pendergrass, M.D., Americus.

"Vascular Grafting"—William A. Hopkins, M.D.; M. Bedford Davis, M.D.; and William C. Wansker, M.D., Atlanta.

Golf Prizes were awarded to Low Gross Winner: Harry Ridley, Atlanta, and Low Gross Runnerup: Harry Rogers, Atlanta. Prizes for Low Net Winners were awarded J. C. Patterson, Cuthbert and Joseph Mulherin, Augusta, who tied.

By unanimous vote the members accepted the invitation of Georgia Medical Society to convene the 1957 Annual Session in Savannah, and also by unanimous vote the members instructed the Secretary to convey the Association's appreciation to Fulton County Medical Society for their superb hospitality during this session.

Radiation Hazards in Diagnostic Radiology

H. STEPHEN WEENS, M.D., and JOHN H. TOLAN, B.S., Atlanta, Ga.

THE WIDESPREAD USE of x-rays in medical diagnosis has created potential hazards which are frequently not taken into proper consideration. Since the discovery of the roentgen ray, various types of radiation injury have been discovered among which damage to superficial tissues has received foremost consideration for many years. The deleterious effect of radiation on deeper organ systems such as the hematopoietic system¹ and the possibility of genetic radiation effects² were, however, not fully appreciated until more recently. The increased incidence of leukemia among physicians, particularly radiologists, amply testifies to these dangerous side effects.³ Obviously these hazards are confined not only to physicians but should equally apply to all technical personnel involved in the performance of radiologic procedures. To some extent they may also apply to patients undergoing radiologic examinations.

It remains therefore the responsibility of all physicians participating in radiologic examinations to be aware of these potential hazards and to acquaint themselves with those steps which may be taken to reduce these dangers. If radiologic procedures are selected intelligently and correct protective measures are applied, it appears likely that the benefits derived from radiologic examinations will not be accompanied by undue danger to radiologic personnel and patients.

In the material to follow an attempt is made to briefly discuss this problem from the standpoint of hazardous radiation levels to radiologic personnel and patients during the performance of diagnostic x-ray examinations. Measures which may be taken to minimize these undesired effects will be described without recourse to excessive technical detail.

Radiation Dosimetry

In order to evaluate radiation exposure in terms of permissible radiation levels an elementary knowledge of radiation dosimetry appears in order. The basic unit in radiation dosimetry is the roentgen—a unit which refers more or less to radiation exposure at a given point. Many other units have been introduced for the measurement of ionizing radiation, but the roentgen remains a most satisfactory unit in the type of x-radiation used in diagnostic procedures. Various measuring devices (roentgen dosimeters) are available today which are reasonably inexpensive and sufficiently accurate for practical purposes.

Since biologic reactions caused by x-radiation are to a large degree dependent not only upon radiation dosage but also on the volume of irradiated tissue, it is always important to consider the size of the body area which is being irradiated. Thus an exposure of a certain number of roentgens to a limited body part such as the hands may be tolerated without ill effects, whereas the same amount of radiation delivered to the whole body may cause definite systemic changes.

Maximum Permissible Exposure

With the increasing awareness of the dangerous side effects of radiation, several interested groups have tried to establish levels of radiation exposure which could be considered as permissible on the basis of accumulated clinical and experimental evidence. It is noteworthy that this maximum permissible exposure value has been reduced several times in the last three decades. Presently the maximum permissible exposure as accepted by various national and international organizations is given as a total body dose of 0.3 roentgen (300 milliroentgens) per week. As an exception, an exposure of 1.5 roentgens per week to forearms and hands is considered permissible. Exposure of this type refers to individuals who are exposed to small dosages of radiation

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for prolonged periods of time, such as the active working life span of a radiologist.

This maximum permissible exposure should not be considered as absolutely tolerable. In many institutions it is believed that radiation levels should be substantially below this maximum permissible exposure. In our own institution we attempt to keep radiation levels at approximately 1/10th to 1/5th of the maximum permissible exposure rate.

One may readily see that radiation exposures received by patients during diagnostic x-ray examinations may greatly exceed this maximum permissible exposure. These patients receive the radiation dosages only during very limited periods of time of their active life span and also to a very limited part of their bodies. Nevertheless, in some selected situations, patients who periodically undergo x-ray examinations over a period of years may accumulate x-ray dosages which should be taken into consideration.

Radiation Exposure to Patients

With the large variety of radiologic procedures, there is a wide range of radiation levels incident to diagnostic examinations. Representative values of some of the more common and important examinations are recorded in Table I.

Skin Doses for Single Exposure
Chest PA 0.1r
Lateral 0.4r
Abdomen AP 1-2r
Lumbar spine AP 1.5-2.5r
Lateral 3-8r
Skull AP 1-2r
Lateral 0.5-1.5r
Fluoroscopic Exposures
Factors: 85 KV, 3 MA
2 mm. aluminum filter
7-12 r/minute at table top

TABLE I

These approximate values represent radiation exposure to the surface of the patient in the center of the irradiated field. Values of this type vary considerably with differences in radiographic factors and tube filtration. At this point it should be stated that in both radiographic and fluoroscopic examination surface dosages may be substantially reduced by adding an aluminum filter of two mm. to the x-ray tube. Such a filter will significantly diminish the very soft irradiation which would otherwise be entirely absorbed by the skin and superficial tissues of the patient and which would not contribute to the radiographic and fluoroscopic image.

As the x-ray beam enters the human body a rather marked attenuation of the radiation dosage occurs, so that of a depth of 10 to 20 cm. the entrance values of the radiation may be diminished to a small fraction of the intensity of the incident beam. Every

effort has to be taken to limit radiation dosages to those segments of the human body which are under diagnostic study. It is most regrettable and the subject of considerable criticism that strict beam limitation in diagnostic radiology is not practiced to the utmost extent. This is particularly true in pediatric roentgenology where diagnostic procedures due to unsuitable cone sizes or neglect frequently approach total body exposure though the area of interest may be confined to a very small part of the infant's body.

Fluoroscopic Procedures. Radiation exposures during fluoroscopic procedures are generally considered to be the highest encountered in diagnostic radiology. Time limitations in fluoroscopy as well as adherence to proper technical factors are of utmost importance. We wish to emphasize that the total duration of chest fluoroscopy should rarely exceed two to three minutes and that most gastrointestinal examinations may be performed in five minutes of total fluoroscopic time. Training in these procedures and consequent shortening of fluoroscopic examinations will reduce radiation exposure to patients and personnel. Even though surface dosages in fluoroscopic procedures may be in the neighborhood of 20 to 30 roentgens in selected skin areas, depth doses incident to fluoroscopic examinations are considerably smaller. A study in our laboratory has revealed that the mid pelvis of the female will actually not receive more than approximately one roentgen during gastrointestinal series or barium enema, provided that careful techniques are followed.⁴

Pregnancy. Physicians are frequently consulted concerning radiologic procedures on women during pregnancy. There is good experimental evidence that the fetus in early stages of gestation displays an increased radiation sensitivity.⁵ Applied to the human fetus this critical period is well within the first trimester of pregnancy. These experimental findings are largely based on radiation dosages in the animal fetus in amounts far beyond that actually occurring in radiologic practice. However, until more experimental evidence has been accumulated, it will be wise to eliminate elective radiographic procedures directed toward the lower abdomen during the first trimester of pregnancy. Chest films properly confined to the thoracic cage in pregnant woman will not deliver significant radiation dosages to the human fetus.

Radiation Exposure to Personnel

Radiation exposure to personnel is in a large measure dependent upon the physical characteristics of the equipment as well as the knowledge and experience of its operator. Though modern radiologic equipment may contain many safety features, the manufacturer cannot guarantee safe operation of the

apparatus. Likewise, there is no substitute for an intelligent understanding of the equipment and knowledge of all possible radiation hazards from the use of such apparatus.

Physicians who do not understand the basic principals of radiographic and fluoroscopic procedures should abstain from performance of such examinations for fear of endangering themselves and their patients.

Fluoroscopy. Even if such protective devices as lead aprons and gloves are constantly used during fluoroscopic examination, radiation exposure to the fluoroscopist may not be insignificant. Unprotected parts of the human body such as the elbows and legs may on a moderately heavy fluoroscopic schedule receive 30 to 50 milliroentgens per week.⁶

Fluoroscopy in the course of orthopedic procedures carries inherent dangers. The unprotected hand of the surgeon should never be exposed to the direct x-ray beam. The use of portable x-ray machines for such procedures appears particularly hazardous, as a fixed and safe alignment of x-ray tube and fluoroscopic screen is usually not possible. Under these circumstances fracture repositions are better checked by roentgenograms than fluoroscopic observations.

There are selected radiographic procedures which for technical reasons require close proximity of physicians to patients. They shall be briefly discussed.

Neurosurgical Procedures. In cerebral angiography radiation fields should be strictly limited to the outline of the skull. It is not uncommon that field size limitation is inadequate so that part of the operator's hands or forearms are exposed in the primary x-ray beam. Under these circumstances, during a single cerebral angiogram several roentgens may be received by the hands of the physician injecting the contrast medium. Even with proper field limitation, the forearm and hand of the neurosurgeon may receive appreciable scattered radiation with values of as high as 50 milliroentgens during a single cerebral angiogram.⁶ One may readily see that a neurosurgeon performing several procedures per week may receive exposure to hands and forearm which approach or exceed the maximum permissible exposure. The need for field limitation and perhaps automatic injection equipment appears obvious.

G-U Examinations. Studies in our laboratory have disclosed that the urologist who stands in close proximity to the x-ray table during one single exposure of a pyelogram may receive total body irradiation in the neighborhood of 30 milliroentgens.⁷ Under these circumstances a busy urologist performing a fairly large number of urologic procedures during a week may receive total body irradiation exceeding maximum permissible exposures. It will be well

for urologists who prefer to stand in proximity to the x-ray table during certain exposures to wear a lead apron or stand behind a permanent protective covering.

Cardiac Fluoroscopy and Catheterization. Unfortunately procedures of this type frequently require prolonged fluoroscopic observations. In several instances radiation exposures of 30 to 70 milliroentgens to the forearm and hands of the operator have been observed during a single cardiac catheterization. Though values of this type are still within the so-called permissible range, they are not sufficiently reduced to a level which one would like to obtain in radiologic departments.

Room Protection

One of the most important factors in radiation protection is adequate distance from the source of radiation or scattering object. As x-ray rooms by necessity have to be limited in size, adequate lead protection of its walls and floors appear prerequisite. It is imperative that x-ray technicians should not stand without protection in proximity to a patient undergoing radiologic examination. The control mechanism of the x-ray apparatus should be so located that the x-ray technician will not receive any direct or scattered radiation. If the control stand for the apparatus is located within the radiographic room, an adequate lead protected booth should be erected. There are today still many installations in hospitals and doctors' offices in which adequate wall and floor protection is not provided, endangering non-radiologic personnel in adjacent office or living spaces. The exact requirements for room protection are described in the *National Bureau of Standards Handbook 41* published by the U. S. Department of Commerce.

Summary and Conclusion

The expanding field of diagnostic radiology and the introduction of newer specialized x-ray procedures have created an increasing number of radiation hazards among physicians in all branches of medical practice. Among the principal points to be considered in the establishment of radiologic techniques are the following:

- (1) A filter of two mm. of aluminum should be added to both radiographic and fluoroscopic x-ray tubes.
- (2) The field of the x-ray beam should be strictly limited to the area of clinical interest.
- (3) Fluoroscopic examinations should be limited in time.
- (4) For fluoroscopic procedures, a selection of 85 KV and 3-4 MA in the examination of adults will provide satisfactory screen illumination.
- (5) Radiologic personnel should not stand in close proximity to the x-ray beam.

(6) In those specialized procedures which require proximity of personnel to the x-ray beam or patient, special protective devices such as lead aprons and lead gloves should be used.

(7) In those instances in which there is suspicion of excessive exposure a personal monitoring device such as a small pocket ionization chamber or a film badge should be worn.

Observation of such rules as well as advances in equipment design and room protection can however only partially meet our demands for reduction of radiation hazards. Of foremost importance in the field of radiation protection appears the physician's understanding of radiation exposure and his full awareness of potential radiation dangers in the use

of x-ray apparatus. If by a process of education, safe working habits can be established, maximum benefits from radiologic procedures will be assured.

36 Butler St., S. E.

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Space Man

IF YOU'RE PLANNING a fast two weeks on the moon—including six days' travel—you'll have to take along at least 100 pounds of food, water and oxygen just for yourself. Anything less may prove fatal, says Dr. Fred A. Hitchcock, professor of aviation physiology at Ohio State University.

This is indeed serious business, says this authority on space medicine. For, as he told the Aero Medical Association during its recent sessions, the Government's current program of earth satellites and pilotless rockets is now just a step away from man-carrying space ships, man-piloted rockets, and fully manned space stations.

When that day comes, the space man will have to be prepared to live in a "fish bowl" on a diet of plants, perhaps simply algae. He won't be able to pick up steak and chops on the way. As Dr. Hitchcock sees it, the space flyer will inhabit a "microcosmos similar to the balanced aquaria that are maintained in many college departments of biology." It may be literally a self-contained capsule equipped with the barest essentials for human life.

Dr. Hitchcock's studies of the physiological and medical aspects of space travel indicate that one man would need five pounds of food, water, and oxygen a day to keep alive away from earth. For a year's stay he would have to carry along more than three-quarters of a ton of such stuff.

So man is going to have trouble establishing permanent bases on the moon unless he has some way of producing his own food and oxygen through some process like photosynthesis the way green plants do.

This is one of the reasons, Dr. Hitchcock says, that makes full understanding of photosynthesis man's number one research project. But space travel isn't the only reason: if the world's population continues to increase, the doctor believes, man may eventually have to exterminate all other carnivores and in the last analysis, for plain down-to-earth survival, he may be driven to vegetarianism.

But even if man solves the riddle of photosynthesis, he will have by no means solved all the problems of space medicine. Finding drinking water may still stump him. And in space, warns Dr. Hitchcock, the traveler must learn to protect himself against the twin hazards of collision with meteorites and of cosmic radiation.

Even if man reaches the moon tomorrow, it will still be a long time, says this authority on space medicine, before the odds on his being killed by a meteoric "sky-road hog" approach those facing America's Sunday driver. There just aren't enough meteorites, large or even medium sized.

Cosmic dust, however, is something else again. Dr. Hitchcock says that experts are not in complete agreement as to the magnitude of the cosmic ray hazard. In fact, research now in progress indicates that mice exposed for 24 hours to cosmic radiation in balloons at 90,000 feet show an increased tendency to gray hair.

So it's not improbable, continues Dr. Hitchcock with a smile, that the space man of the future will not only be a vegetarian but prematurely gray as well.

(Reprinted from *Medical News*. Vol. 2, No. 10, May 7, 1956)

Acute Renal Insufficiency

ARTHUR M. KNIGHT, JR., M.D., Waycross, Ga.

MOST PHYSICIANS are quite familiar with the correct treatment for congestive heart failure, but many do not yet know what to do when faced with failure of another vital organ, the kidney. Because renal failure is quite common, the author feels that it is worthwhile to review with you certain useful facts about this frequently fatal clinical situation.

By the term acute renal insufficiency we mean^{1, 2} sudden and virtually complete failure of renal excretory function, usually due to acute circulatory or toxic insult to previously normal kidneys, a situation which is potentially reversible. Many different names and descriptive terms for this clinical condition may be found in the literature, including the following: ^{3, 4, 5} reversible uremia, crush syndrome, lower nephron nephrosis, renal anoxia syndrome, hemoglobinuric nephrosis, myo-hemoglobinuric nephrosis, renal tubular necrosis, acute tubular degeneration, and necrotizing nephrosis. Perhaps the most rational and descriptive term is renal tubular necrosis.

The etiology^{5, 6} of acute renal insufficiency is either renal ischemia,⁷ nephrotoxic substances,⁸ or both,⁹ and the lesions in the kidney can result from peripheral circulatory failure,¹⁰ shock, shock-like states,⁹ impaired renal blood flow, excessive pigment excretion,⁶ poisons, or sensitizing agents. Anemia and heart failure¹⁰ can be contributory factors.

The commonly encountered clinical causes of renal ischemia (from shock or peripheral circulatory failure) may be summarized as follows:^{2, 3, 4, 5}

1. Trauma: massive wounds, multiple fractures, surgery
2. Head Injury
3. Profound Hemorrhage: placental, post-partum, ectopic pregnancy, peptic ulcer, vascular injury, etc.
4. Severe anoxia: carbon monoxide, anesthetics, asphyxia
5. Myocardial or pulmonary infarction
6. Dehydration: profound fluid loss, intestinal obstruction, diabetic acidosis,¹⁰ severe diarrhea, fluid restriction, depletion of electrolytes, etc.

Some clinical causes for renal failure due to pigment excretion include:^{4, 6}

7. Crush Syndrome: massive crushing injuries
8. Incompatible blood: transfusion accident⁶
9. Blackwater fever: hemolysis due to malaria
10. Transurethral resection: water into blood stream
11. Heat stroke
12. Hemolytic anemia
13. Burns, thermal injury, electric shock
14. Hemoglobinurias: cold, familial, march, etc.
15. Hemorrhagic fever
16. Sickle cell crisis

Among the nephrotoxic substances or sensitizing agents which can damage the renal tubules and cause acute insufficiency, the following can be listed:¹¹

17. Heavy metals: uranium, bismuth, mercury, phosphorus
18. Organic compounds: CCl_4 ,⁸ cresol, chlorate, mushroom poison, black widow venom, diethylene glycol
19. Sulfonamide sensitivity: vascular lesion (less common than crystals in tubules)
20. Bacterial toxins: meningococcus, staphylococcus, typhus, leptospirosis, peritonitis, other severe infections
21. Eclampsia (also pregnancy without toxemia)
22. Serum sickness
23. Antibiotics: viomycin, bacitracin

Diagnosis

The diagnosis¹ of acute renal failure must be considered in any patient who voids less than 1,000 cc. of urine in 24 hours. The blood N.P.N. or B.U.N. will be elevated. The urine will be dilute. There will be a history of recent shock, cause for pigment excretion, or contact with a nephrotoxic agent. One must rule out immediately reversible shutdown,^{12, 13} as in obstruction, heart failure, shock, or severe dehydration (though these situations can also lead to severe renal damage). It is also important to rule out unrecognized chronic diseases, such as glomerulonephritis, malignant hypertension, and pyelonephritis. A very rare cause of shutdown is bilateral obstruction of the renal vessels by emboli.

Pathologists⁷ describe microscopic findings due to toxins and those due to ischemia, as well as changes due to regeneration. Because there is an even distribution of the toxin to every nephron, and because the toxin is absorbed by the cells of every proximal

Presented before the Annual Meeting of the Eighth District Medical Society.

tubule, these latter cells die, and other portions of the nephron are not affected by the nephrotoxic lesion. The distal tubules contain coagulated protein (casts) and dead epithelial cells. In the case of the ischemic lesion, however, there is a random involvement of nephrons, many being spared. Though any part of the nephron may be damaged, the commonest site is the second half of the proximal tubule. The ischemic lesion affects a short portion of the tubule or isolated spots. Because the epithelium dies and desquamates and the basement membrane is destroyed, the tubule is disrupted and an inflammatory reaction occurs at the site of the breach. In sections one also sees evidence of regeneration of tubules. Not all nephrons are restored and function returns only to the least damaged nephrons.

Clinical Course

The clinical course^{1, 2, 3, 11, 12} of acute renal insufficiency may be divided into several phases. The onset phase lasts for only a few hours and is the period during which the toxin is acting or the time in which the patient is in a state of shock. Then follows the oliguric (or anuric) phase in which the daily urine volume is less than 1,000 cc. for a few days to two weeks or more. In the diuretic phase the urine volume increases and may become enormous if fluids have not been properly restricted during the oliguric phase. The diuretic phase is followed by the recovery phase, requiring from one to four weeks after the onset of diuresis.

Several important complications can occur.^{14, 15} In the oliguric phase one must try to prevent or treat hypervolemia, edema, *pulmonary edema*, acidosis, bronchopneumonia, hypertension, convulsions, and *hyperkalemia*. In the diuretic phase the dangers are dehydration, electrolyte depletion, tetany, hypokalemia (muscular paralysis, cardiac arrest), hyponatremia, and hypochloremia. The cause of death^{16, 17} may be the primary trauma or disease state, *pulmonary edema*, *hyperkalemia*, hypokalemia, or non-specific complications, (such as pulmonary embolus). The commonest causes are those in italics, and our efforts can often be successful in preventing these.

The prognosis² in acute renal failure is excellent in uncomplicated ischemic cases with adequate treatment, though a small percentage of these are irreversible. It is good in nephrotoxic cases if treatment (e.g. BAL for mercury) is given soon enough and long enough and if the dose of the toxin is not too large.

Treatment

Emergency treatment^{2, 9, 11, 12, 13} consists in attacking the underlying defect. Severe hypotension must be corrected. For hemorrhage, blood should be given. If the hematocrit is high (dehydration),

one should use plasma. If it is low or normal, it is best to use packed red blood cells. Levophed raises the pressure by causing vasoconstriction, but is thought to increase renal blood flow. It is best to avoid serum albumin if the hemotacrit is high, because it decreases the interstitial fluid volume.

Fluid and electrolyte losses should be replaced, but one must remember that saline and blood may produce hypervolemia if the renal tubules have already shut down. If there is a question of obstruction to the ureters or urethra, the help of a urologist should be secured to relieve it. Where intravascular hemolysis has occurred, it is popular to attempt to alkalinize the urine to dissolve heme casts. This, however, is not entirely rational since the anuria is due to ischemia of the tubules rather than to their obstruction.^{6, 7, 10} In any event, one should avoid giving more than 5 Gm. of NaHCO₃.

For heavy metal poisoning the stat dose of BAL is five mg. per Kg.¹¹ This should be followed by 2.5 mg./Kg. every two hours for 10 to 14 days. Procedures which should be avoided in all cases include¹⁸ renal decapsulation, spinal anesthesia, I.V. procaine, and steroid administration. For sulfonamide concretions, the urologist should lavage the renal pelves with warm NaHCO₃ solution.

In the oliguric phase the aim of treatment is to keep the internal environment as near normal as possible and to keep the patient in an optimal state until spontaneous healing and diuresis have occurred.¹⁹ One must prevent endogenous protein breakdown,²⁰ which produces acidosis, azotemia, and intoxication, and releases potassium ions and phenols. This is attempted by giving a high caloric intake from carbohydrate and fat and by avoiding exogenous protein.²¹ The patient may be given butter, salad oil, or the proprietary preparations Lipomul or Ediol.^{18, 22} He may be permitted to eat lump sugar or hard candy (free from eggs, nuts, or cream of tartar). Sweet tea may be given. If carbohydrate and fat are not taken by mouth, they can be administered through a naso-gastric tube as sugar solutions or edible oils. A 10 per cent solution of invert sugar can be safely given subcutaneously. Some authorities give 50 per cent dextrose by continuous drip through a plastic catheter threaded into the great veins (to prevent thrombosis).^{2, 11, 12}

Fluid administration must be done with the greatest care to prevent "drowning the patient." Existing losses must be corrected. An accurate intake and output chart must be kept. The daily loss in the urine must be replaced as well as fluid lost via the G.I. tract. Insensible fluid loss must also be replaced, and amounts to one-half c.c. per Kg. per hour (more in children and when active). More fluid must be given if the patient has fever or is sweating. The pa-

tient should be weighed each day and permitted to lose one pound per 24 hours. It is seldom necessary to give more than 850-1,000 cc. of fluid daily.

Any electrolyte solution given in the oliguric phase must be free from potassium. One should never give potassium to a patient with oliguria.^{16, 17, 20} If the patient is vomiting, chloride losses must be replaced; if he has diarrhea, sodium losses must be restored. One gram of NaCl daily is enough to cover insensible loss, but more salt is needed if the patient is sweating. If the serum sodium level is low, it is usually because of dilution of the extracellular fluid or due to intracellular movement of sodium ions.²⁰ This situation is corrected by restricting water. The serum K⁺ level should be determined daily, and it is also desirable to get daily levels of Na⁺, Cl⁻, NPN, and CO₂.

Infections must be treated vigorously¹² because they result in increased protein catabolism. Because the patient is under great stress and because of the high carbohydrate intake it is important to give a generous supply of vitamins.^{11, 23} Since male sex hormone has an anabolic effect, some authors advocate 50 mg. of testosterone propionate daily.¹²

Congestive heart failure¹³ is treated with digitalis and restriction of fluids and sodium. Diuretics must be avoided. If fluids are given intravenously, they must be given very slowly. One should give digitalis with caution if the potassium level is low.

Unless anemia is severe, it is best to avoid transfusions because red cell breakdown releases potassium.⁶ If blood must be given, it must not be bank blood but should be fresh. Packed red cells are preferable to whole blood because of the danger of producing hypervolemia.

Potassium intoxication¹² occurs if the serum level rises much above five M. eq. (20 mg. per cent).¹⁶ Everything possible must be done to prevent this, since it results in cardiac standstill.¹⁷ Cation exchange resins² (sodium cycle) can be given orally or by retention enemata to reduce the K⁺ level, but care must be taken to avoid producing hypocalcemia. Prompt though relatively brief lowering of potassium may be accomplished by giving NaCl or NaHCO₃ intravenously. Calcium gluconate I.V. helps to counteract the toxic effects of K⁺.¹⁷ Hypertonic glucose plus insulin will also bring about temporary lowering of serum potassium.¹² Peritoneal dialysis or the artificial kidney must be used if these measures prove ineffective.^{24, 25, 26, 27, 28}

In the diuretic phase large quantities of NaCl and K⁺ may be lost in the urine, resulting in a rapid fall in the blood levels of these electrolytes.²⁰ They must be replaced in order to prevent death from hypochloremia and dehydration. This is accomplished by saving all urine and analyzing the 24-hour specimen

for Na⁺, K⁺, and Cl⁻. NaCl and KCl are given as indicated.

If the serum Na⁺ and Cl⁻ levels rise in the diuretic phase it is due to excessive reabsorption by the tubules.¹¹ This complication is treated by restricting NaCl and forcing water.

In the recovery phase it is important to continue careful replacement of urinary losses until the kidney regains its functional selectivity.

Summary

Acute renal failure is not uncommon and is potentially reversible. It is caused by renal ischemia or nephrotoxic substances. The N.P.N. goes up, and the urine volume and specific gravity go down. Renal tubule cells die but many can regenerate. The oliguric phase may last two weeks or longer, being followed by prolonged diuresis and eventual recovery. The chief dangers are hyperkalemia and pulmonary edema. Emergency treatment consists in correcting shock (or giving BAL). In the oliguric phase protein breakdown must be prevented and fluids must be restricted. Potassium must never be given to oliguric patients. Supportive therapy is important. In the diuretic phase fluid and electrolyte losses may be considerable and must be replaced.

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Polio Decrease Possible

ASSERTING THAT THE SALK vaccine can cut paralytic polio in half this summer, Basil O'Connor, *NFIP* President, said that distribution and use of the vaccine have become a logistic rather than a scientific problem.

To achieve the maximum possible cut in paralytic polio this summer will depend on the coordinated efforts of the public, public health services, doctors and vaccine manufacturers, Mr. O'Connor said. He estimated that with this cooperation during the remaining months of 1956 paralytic polio can be reduced to a negligible amount in 1957.

Outlook Based on Estimated Vaccine Supply

Mr. O'Connor based his analysis on the amount of vaccine that manufacturers estimate they can produce in the months just ahead in relation to the number of individuals most susceptible to polio.

According to manufacturers' estimates, by July 10th, 1956, sufficient vaccine will have been produced to give two shots to all children through 19 years of age plus pregnant women for a total of 65,000,000 individuals.

Mr. O'Connor arrives at his figure of a 50 per cent reduction in paralytic polio during the 1956 epidemic season by using the following calculations (by coincidence the three percentages used in these calculations are the same):

1) Start off with the knowledge that the prime vaccination group mentioned above (0-19 and pregnant women) accounts for 80 per cent of all paralytic polio that can be expected.

2) Take 80 per cent of this, representing the number of children and pregnant women who can be expected to accept the vaccine; this gives you 64 per cent ($80\% \times 80\% = 64\%$).

3) Then take 80 per cent of this last figure, representing the assumed effectiveness of the vaccine and you get 51.2 per cent, or roughly the 50 per cent foreseen by Mr. O'Connor.

Shots for 97 Million

By December 31, 1956, manufacturers estimate that sufficient vaccine will have been produced to assure at least two shots of vaccine for 97 million people, or about 80 per cent of the population aged 0 to 45. Less than 2 per cent of all paralytic polio occurs in the age groups over 45. Intelligent use of the vaccine during this period could almost wipe out paralytic polio, Mr. O'Connor stated.

Important Assumptions

Concentrating on the immediate job of halving the rate of paralytic polio in the 1956 epidemic period, he said this could be done assuming that:

1) manufacturers will make every effort to live up to their production estimates

2) the U. S. Public Health Service through the National Institutes of Health will be ready to release promptly for public use all properly manufactured vaccine presented to it

3) parents of children in the 0-19 groups will have vaccine given to their children when and as it becomes available

4) local public health officials and doctors will let the public know promptly when vaccine is available, and

5) doctors will not hold in reserve vaccine for second shots, but will give one shot to as many individuals as possible in the age group 0-19 and pregnant women relying on second shots to be available before June 30, 1956.

The job of giving 97 million people at least two shots of Salk vaccine before December 31, 1956, Mr. O'Connor said, is not impossible, but must be worked out by public health officials and the medical society in each state as an emergency health program.

(Reprinted from *National Foundation News*, Vol. 15, No. 5. May 1956).

Congenital Lung Cysts

A Review of the Literature and Case Report

H. LUMPKIN COFFEE, M.D., Milledgeville, Ga.

IN 1953, CAFFEY¹ stated that the number of authentic cases of prenatal and neonatal pulmonary cysts is surprisingly small. Potter, in her large experience with fetal lungs, has found only two examples of fetal cystic diseases. The two cases that she has observed were both in stillborn infants.

Congenital cystic disease has not been found at necropsy at the Babies Hospital during a period of 50 years.² Schenck quotes Lederer as having failed to find a single instance of this disease in 5,000 necropsies. It is now evident that many cases which have suggested congenital cystic disease roentgenographically were probably examples of acquired emphysematous cavities caused by check valve bronchial obstruction.

Therefore, this case was of special interest since this infant lived three days before expiring.

Case Report

The mother of this infant was a 26-year-old white female GV P IV admitted to the labor room of the Elmhurst Memorial Hospital, Elmhurst, Illinois, in labor 8-31-54.

EDC August 8, 1954.

LMP November 1, 1953.

The mother had an uneventful pregnancy up until the first stage of labor at which time she began bleeding bright red blood. Vaginal examination confirmed the diagnosis of placenta previa marginalis. The membranes were ruptured. The infant's head came down and a normal spontaneous delivery followed. The mother had an uneventful post partum course.

Her previous pregnancies had been uncomplicated except for her third child which was a premature breech delivery. There was no history of any congenital anomalies in her family or any of her other children.

The baby was a boy, 5 lbs. 11 oz. at birth. The infant cried immediately after delivery. There were no anomalies or injuries seen. Physical examination at birth was negative. The following day the infant developed a grunting respiration with slight chest retraction and some cyanosis. He was placed in an incubator with oxygen and his condition improved immediately. The next day his condition was more acute with greater chest retraction and dyspnea. Respiratory rate was 10 per minute. Pulse rate was 150 per minute.

Physical examination at this time showed marked

cyanosis of the extremities and lips. Head—negative. Chest—limited respiratory excursion on the right. Lungs—hyperresonant percussion note over right chest. Breath sounds absent on right. Tracheal shift to the left. Heart—heart sounds distant and displaced to the left. Abdomen—negative. Genitalia—negative. Extremities—negative. Reflexes—negative. X-ray at this time revealed right pneumothorax.

The diagnosis of right tension pneumothorax was made, and a thoracentesis was done. Eighty cc. of air was withdrawn from the right pleural cavity and marked improvement occurred. (Two more thoracentesis were done with about equal results. The infant expired just before a closed thorocotomy could be done.)

Autopsy

On opening the peritoneal sac no fluid was found. The liver was engorged but not enlarged. Otherwise findings were negative. The chest was opened, and there was a pneumothorax of the right side. All lobes of the right lung showed multiple cysts up to 14 mm. Some were trabeculated. The left lung was partially atelectatic but floated in water. The heart was normal in size. The right side was dilated slightly. There were no congenital anomalies of heart or vascular tree.

Anatomical Diagnosis

- 1) Cystic disease of right lung with rupture and pneumothorax.
- 2) Shift of mediastinum due to pneumothorax.
- 3) Partial atelectasis of left lung.

Histological Description

There were multiple thin-walled cysts seen in the lung tissue. They were lined with low cuboidal cells on the inner surface of the cyst wall.

Discussion

Kimbrough and Lull³ state that the incidence of congenital anomalies of the fetus is definitely higher than normal in placenta previa, and it is thought to be due to the relatively poor nourishment which the placenta can obtain from the less satisfactorily vascularized lower uterine segment.

The occurrence of the cystic disease of the lung in a new-born infant establishes it as congenital. The embryologic mechanism and the time of formation of the defect have not been established. The various defects are usually not accompanied by major defects in other organs. The majority of the cases reported in the literature are single or multilocular large lung

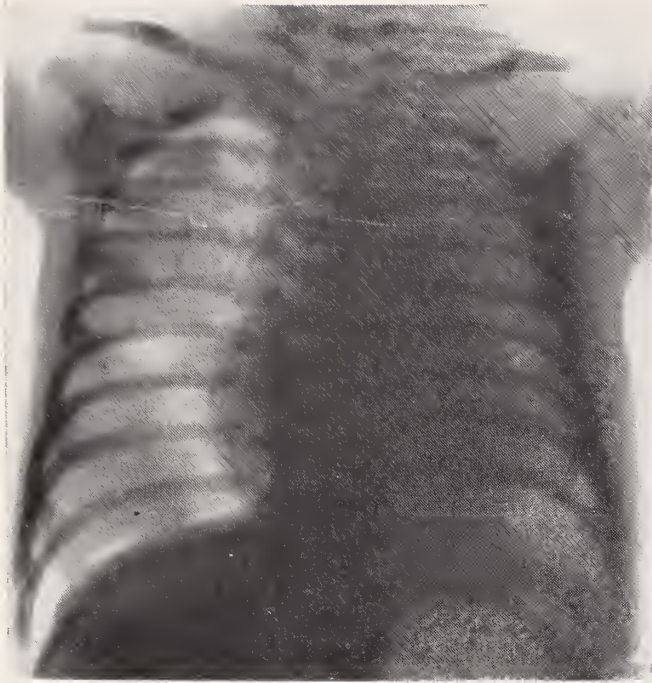


Figure 1
Tension Pneumothorax (Right)

cysts with occasional cases of honey-combing. A honey-combed lung suggests that it is the small peripheral bronchi which have failed to establish communication with the air spaces.

Acquired cystic disease of the lung occurs as a consequence of inflammatory reaction and usually occurs in an older individual.⁴ Cicatricial tissue around bronchi, bronchioles, and alveolar ducts can produce an obstructive emphysema of the bullous type, so that cavernous spaces of considerable size develop in pulmonary parenchyma.

The histological picture of congenital cystic disease is that of an epithelial lining made up of columnar ciliated or low cuboidal cells on the interval face of the cyst wall.

Five possible diagnoses must be considered in such a case:⁵

1. Congenital lung cyst.
2. Congenital diaphragmatic hernia.
3. Pneumatocoles secondary to staphylococcus pneumonia.
4. Tension pneumothorax.
5. Congenital labor emphysema.

The outstanding symptoms, dyspnea and cyanosis, are the same in each condition.

After the definite diagnosis of these expanding lung cysts or of tension pneumothorax has been made and confirmed by Roentgenographic examination,

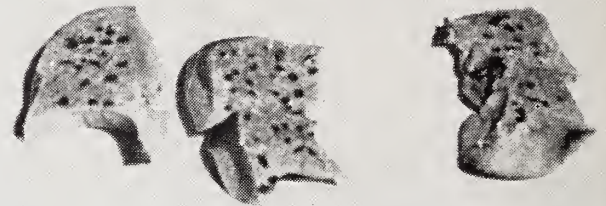


Figure 2
Above—Gross Specimen (Lung)
Below—Cross Section of Right Lung

the infant must be treated rapidly by one of the following possible measures:

1. Thoracentesis.
2. Closed thoracotomy with tubing connected to a sealed water bottle.
3. Lobectomy or pneumonectomy.

Summary

A review of the literature reveals that congenital pulmonary cysts are extremely rare. A case history of congenital pulmonary cysts has been presented.

This anomaly was of congenital origin and was accompanied by no other congenital defects.

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Do You Know?

ONE OUT OF EVERY FIVE Americans now owes money to his physician, dentist, or hospital and even

among families in the income bracket of \$7,500 a year or more, one in ten owes for medical services.

Renal Vein Thrombosis

ALFRED JOSEPH GREEN, M.D., and L. MINOR BLACKFORD, M.D., Atlanta, Ga.

WHILE RENAL VEIN thrombosis is rarely diagnosed clinically, it is not a particularly rare condition. Since it is more common in the very young, a few examples of it may be expected in every large series of pediatric autopsies. There is no predilection as to sex, and about half the cases are bilateral.

Unilateral renal vein thrombosis is often thought to be Wilms tumor. Campbell and Matthews¹ (1941), exploring with this diagnosis, found unilateral renal vein thrombosis and removed the affected kidney. A few weeks later in a similar case they made the correct diagnosis preoperatively. Both children recovered.

It is generally agreed that Campbell and Matthews were the first to make the clinical diagnosis and prove it, but it would be difficult to estimate the number of correct diagnoses made during life, including those diagnosed at operation. So far as our research has gone, the number stands at around a dozen. It would be even more difficult to determine the total number of cases reported. In 1953, Milburn² claimed that his case (in which he diagnosed unilateral thrombosis and effected a cure) was the 258th on record. A year later Clatworthy, Dickens and McClave³ reported 10 children ill with diarrhea who exhibited urinary abnormalities. Six infants whose kidneys could not be palpated recovered. In four a mass was discovered in the region of one or both kidneys. At operation on one of these, unilateral thrombosis was verified, the kidney removed and the infant recovered; the other three died.

Thrombosis of the renal vein or veins occurs most commonly in infants dehydrated by several days of colitis, often complicated by infection elsewhere. When such a baby suddenly begins to pass only small amounts of bloody urine (though blood is not invariable), and develops a tender mass in either flank or both, the diagnosis, if thought of, will not be missed. If only one renal vein is involved, more elaborate urologic procedures may be necessary to establish the diagnosis.

Renal vein thrombosis is important out of all proportion to its incidence because when it is uni-

lateral, surgery offers a good chance of cure. In the words of Campbell and Matthews, "With operation 75 per cent live; without operation 95 per cent die."

Report of Case

On December 7, 1954, a white infant of four weeks, who had been thriving on an evaporated milk formula, became fretful. The next day a watery diarrhea set in. On the 9th the diarrhea worsened and the temperature rose. She began to vomit and it was necessary to feed her with a dropper. Failing to improve, she was brought to the Eggleston Hospital on December 11.

On admission she weighed five pounds, four ounces (2850 Gm.), a gain of five ounces (142 Gm.) since birth. Temperature was 103.4, pulse 168, respiration 50. She was lethargic and cyanotic. Severe dehydration was evidenced by the sunken anterior fontanel, the dryness of the mucous membranes, and the coated tongue. Crackling rales were heard over the lower chest. The abdomen was soft: the liver was down about two fingerbreadths, but no mass was palpable in either flank. No urine was available for examination. The carbon dioxide-combining power was 12 milliequivalents per liter. We ordered intravenous fluids with sodium bicarbonate for the correction of the acidosis, with penicillin and chloramphenicol parenterally.

The next morning color and hydration were improved. The small amount of urine collected showed traces of sugar and acetone, with many uric acid crystals. Urine that afternoon became dark red, and it contained innumerable erythrocytes. Later, because of slight periorbital edema and other signs of fluid retention, intravenous fluids were discontinued for the night.

On the 13th she drifted into coma. The liver was down three fingerbreadths, and a mass measuring about three by five cm. was felt in each flank. She was voiding just enough to stain her diaper with blood. At this time, recognizing the similarity of this case to one studied a few months earlier by one of us (A. J. G.) at Grady Memorial Hospital which was diagnosed at autopsy, the diagnosis of bilateral renal vein thrombosis was made. Roentgenologic studies confirmed the enlargement of both kidneys.

In terms of milliequivalents per liter, carbon dioxide was 13, chloride 114, and sodium 147 (potassium determination that day was technically unsatisfactory); the non-protein nitrogen was 118 milligrams per hundred cubic centimeters. We decided to give fluids necessary to take care of insensible water loss, to digitalize the baby, to continue the antibiotics, and to follow the electrolytes, including potassium, daily. The next day the carbon dioxide combining power was 13, chloride 111, sodium 143 and potassium 5.8; the non-protein nitrogen was 122.

On the 15th, little clinical change in her condition was apparent. The carbon dioxide combining power was 15, chloride 113, sodium 143 and potassium 9.0;

From the Henrietta Eggleston Hospital for Children and the Emory University School of Medicine.

Presented before the Fulton County Medical Society, June 2, 1955.

Report of a Case Diagnosed Clinically, with Electrocardiogram Evidencing Severe Retention of Potassium



the non-protein nitrogen was 138. An electrocardiogram that evening was interpreted (before the reports of the blood chemistry were received) as evidence of extreme hyperkalemia (in the range of 10). The baby died about two hours later.

The pathologists reported thrombosis of the left renal vein with massive infarction of that kidney; thrombosis of some intrarenal branches of the right renal vein with scattered areas of infarction of the right kidney.

Discussion

Although in this case both kidneys were affected and therefore surgery offered nothing, we hope that this report will make possible the more frequent diagnosis of renal vein thrombosis and perhaps save the lives of some children with unilateral involvement.

The realization of the importance of the concentration of potassium in the blood is increasing every day. This case illustrates again how much simpler and especially how much quicker it is to determine dangerous levels of potassium by an electrocardiogram than by the more elaborate chemical procedures, which are not even available in many hospitals.

Summary

Another is added to the short list of clinically diagnosed cases of renal vein thrombosis. In this an electrocardiogram taken shortly before death corroborated the presence of extreme retention of potassium.

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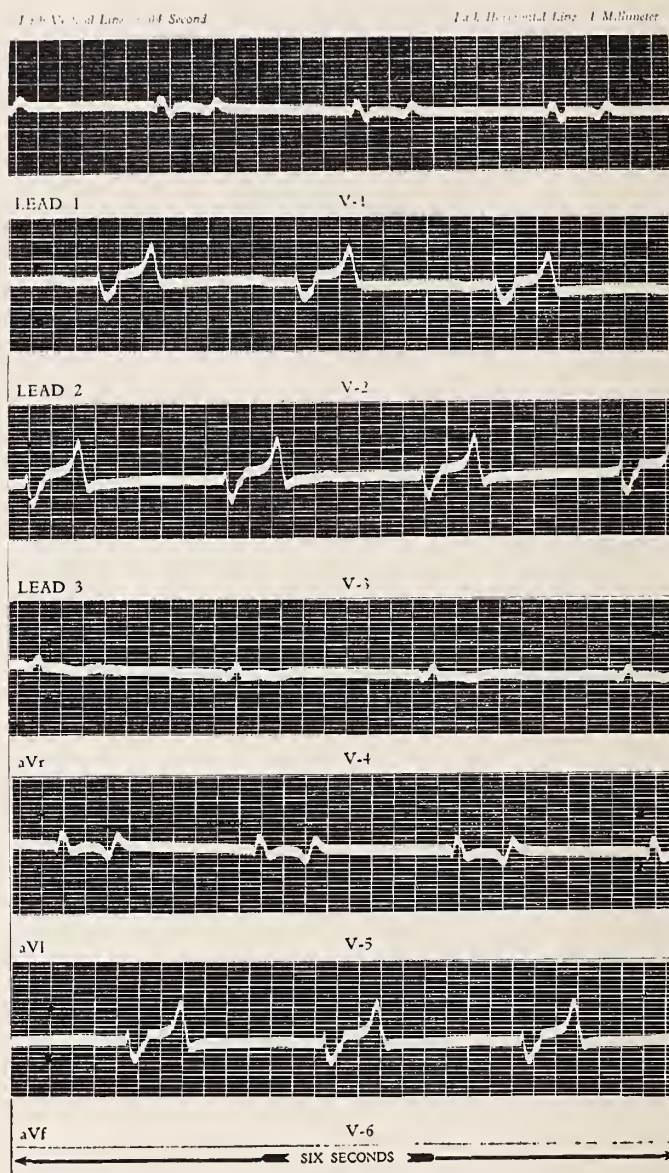


Figure 1

The absence of P-waves indicates auricular arrest; the ventricles are beating independently at 35. The R-waves are low. The QRS-complexes are prolonged to 0.20 seconds. As seen best in leads 2, 3 and aVf, the elevated ST-segments run right into the high, peaked T-waves. This tracing suggests that potassium is in the range of 10 milliequivalents per liter. The normal is about 5. Chemical determination of potassium in blood taken about 11 hours earlier was 9.

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Breast Cancer on the Increase

APPROXIMATELY 52,000 women are found to develop breast cancer each year, according to the American Cancer Society.

Other recent Cancer Society statistics on the mastectomy problem:

- 21,000 deaths occur annually, despite 31,000 mastectomies.

- The six-year average survival rate for untreated cases is only 15%.

- For those who undergo surgery and have no axillary node involvement, five-year survival rate is between 55% and 80%.

- In cases with axillary node involvement, radical mastectomy results in a five-year survival rate of 18% to 45%.

Torsion of the Pedicle of Ovarian Cysts

M. E. SCOTT, M.D., and W. P. WOODALL, M.D., Thomaston, Ga.

OVARIAN TUMORS are very uncommon in children under 15 years of age. They comprise about one per cent of all childhood tumors.¹ From a review of literature presently available, there have been approximately 200 cases of ovarian tumors reported in children under 15.¹ Approximately 20 to 25 per cent of ovarian tumors are of the dermoid group.² The youngest case previously presented of a twisted dermoid ovarian cyst was in a three-year-old. This case was presented in the *Journal of the Medical Society of New Jersey* in May, 1955, Vol. 52 number 5.²

From the previous literature reviewed it appears that the following symptoms were usually found in ovarian tumors in children: (1) intermittent lower abdominal discomfort; (2) progressive enlargement of the abdomen; and (3) episodes of acute abdominal pain resulting from torsion of the pedicle.³ Pre-operative diagnosis was not usually made in children with ovarian tumors.⁴ There are two cases presented below. One is in an infant two years and 11 months old. As far as we have been able to determine, this is the youngest person to have torsion of the pedicle of a twisted dermoid cyst. The second case is in a four-year-old child.

Case No. 1

S. H., a two year, 11 months old colored infant was first seen on September 9, 1954. The patient had had cramping abdominal pain particularly in the right lower quadrant for about eight hours. The mother and father had noted that the child had not had a bowel movement for the previous 48 hours. There was no rectal bleeding. Her temperature was 100.4 degrees rectally and the white count, done in the office, was 11,871 with 84 per cent neutrophils, 12 per cent lymphocytes, and three eosinophils. There was a definite tender mass about six by four cm. felt in the right lower quadrant. The patient was admitted to the hospital where consultation was obtained, and it was the opinion of both physicians that this probably represented a case of intestinal obstruction, type undetermined. X-rays obtained were not satisfactory due to movement. The patient was prepared for operation, and a right rectus incision was made overlying the area of the abdominal mass. On operation there was a well defined, smooth, well encapsulated mass in the right lower quadrant of the abdomen. The tumor mass was found to be a cyst of the right ovary. The pedicle of this tumor measured about three cm. in length; it was twisted on its base with a great deal of swelling around the area

of torsion. The mass was removed in toto; it measured six by five cm. It was opened and found to contain sebaceous material and some areas of bone and cartilage formation. The patient had an uneventful hospital recovery and was discharged on the fourth hospital day without complications. She has been seen approximately four times within the last year. Her condition is satisfactory. She has had no other abdominal complaints.

Case No. 2

A. M. M., a four-year-old colored female was first seen on April 11, 1953. She complained of pain in her stomach of two days duration and nausea but no vomiting. Patient also complained of dysuria. Physical examination showed no positive findings, except for tenderness in the lower abdomen. White blood count was 19,600. A catheterized specimen of urine was negative. Exploratory laparotomy revealed a left ovarian mass about four by three cm. It was twisted on its pedicle. This mass was removed, and a routine appendectomy was done. The pathological diagnosis was strangulated teratoma of the ovary. The patient had an uneventful hospital recovery and was discharged on the fourth hospital day.

Discussion

From a review of the literature it appears that the earliest age at which a dermoid cyst with a torsion of its pedicle has previously been reported was in May 1955 in the *Journal of the Medical Society of New Jersey* in a three-year-old child. As with Case One presented above, the pre-operative diagnosis was not made. A typical triad of symptoms usually appear in ovarian tumors. Two of these were present in our cases under discussion. In Case One of our cases reported an X-ray was obtained of the abdomen, however it was technically unsatisfactory due to movement in the child.

Summary

This is a report of two cases of ovarian cyst. One of these is in an infant, two years and 11 months old, the other case presented was in a four-year-old. Ovarian tumors in children under four years old are extremely uncommon, and as far as we have been able to determine from a review of the literature the first case presented is the youngest case of a twisted dermoid cyst of the ovary that has been presented. From a review of available literature it appears that follow-up studies are necessary to determine if cyst formations will occur in the remaining ovary. Diagnosis should have been aided by X-ray, but in our

cases X-ray did not aid in our pre-operative studies. Ovarian tumors are an uncommon cause of abdominal pain in young females, however they must be considered in a differential diagnosis.

Upson County Hospital

REFERENCES

1. Reprinted from the *American Journal of Diseases of Children*, August 1948, Vol. 76, pp. 127-153.
2. *The Journal of the Medical Society of New Jersey*, May, 1955, Vol. 52, No. 5.
3. *The Journal-Lancet*, May, 1949.
4. Reprinted from the *American Journal of Obstetrics and Gynecology*, October, 1949, Vol. 58, No. 4, pages 718-726.

House of Delegates Actions

THE HOUSE OF DELEGATES of the 106th Annual Session elected Thomas W. Goodwin, Augusta, as House speaker, and Fred H. Simonton, Chickamauga, as vice-speaker, and at their second session elected the men to this office for a three year term. In addition to the reports of officers and committees, some 13 addendum reports were introduced. Also there were 16 resolutions submitted for the delegates' consideration. Six reference committees deliberated on this material and then submitted their recommendations to the House for disposition. (This material will be published in full as Proceedings in the June issue of the *Journal of the Medical Association of Georgia*.)

The items of greatest interest before the House were resolutions on the Eugene Talmadge Memorial Hospital and proposed revision of the MAG Constitution and By-Laws.

The Talmadge Memorial Hospital Resolution submitted by MAG Council was passed after discussion and is printed as follows:

RESOLUTION

WHEREAS, the problem of ethical operation of the Eugene Talmadge Memorial Hospital has been of great concern to the Medical Association of Georgia for the past several years; and,

WHEREAS, in the interests of medical education and medical practice in this state this problem must be resolved

THEREFORE, BE IT RESOLVED, that this Reference Committee, realizing its responsibility in this matter, wishes to submit the following recommendations:

(1) That the House of Delegates reiterate its conviction that the operational plan of the Eugene Talmadge Memorial Hospital, as approved by the Board of Regents, March, 1955, fails to meet the standards of medical ethics of the Medical Association of Georgia and American Medical Association in the following categories:

- (a) The plan permits the possible exploitation of physicians on the faculty of the Medical College of Georgia for the pecuniary gain of the State
 - (b) The plan deprives the physician of a voice in the expenditure of funds derived from the professional services rendered
- (2) The Reference Committee further requests that the House of Delegates petition the Board of Regents and the President of the Medical College of Georgia to

take the following steps in order to correct these deficiencies in medical ethics:

- (a) Amend the plan to provide means by which the wishes of physicians referring patients to the hospital will be respected in assigning those patients to the faculty members. It is understood that the staff, however, reserves the right to assign patients to such services and attending physicians as may best meet the needs of the patient.
- (b) Amend the operational plan to allow faculty members to see patients in other hospitals other than government hospitals when so requested by physicians, under extraordinary circumstances.
- (c) Amend the operational plan to provide means whereby physicians rendering professional services to patients may bill those patients directly. The patient will be instructed to pay such fees into the Research Fund at the Medical College of Georgia in the name of the physician who rendered the service.
- (d) Amend the operational plan to provide that in no fiscal year shall the monies collected from professional pay patients exceed 20% of the amount of the combined salaries of the Medical College faculty.
- (e) Amend the operational plan to provide means by which faculty members turning money into the Research Fund shall be permitted to make recommendations and be consulted as to how such monies shall be expended.

BE IT FURTHER RESOLVED, that there is great need for adequate legal counsel and advice by the Medical Association of Georgia on this problem, and it is therefore recommended that the Association employ the services of the most competent legal counsel to study and advise the medical profession regarding the status of medical practice in the State of Georgia; and

BE IT FURTHER RESOLVED, that nothing in this resolution be construed to imply that the Medical Association of Georgia is taking any legal steps against any hospital, the Board of Regents, or any other agency or organization, but simply means that the House of Delegates believes that legal counsel and advice is needed in order to solve this overall problem of the corporate practice of medicine. It is further felt that matters pertaining to the field of medical ethics should be judged solely by the Medical Association of Georgia and its component county medical societies and that matters of law should be handled and judged by the Association Legal Counsel.

The Management of Emergency Hemorrhage During Surgery

ALL SURGEONS AT SOME time are confronted with a large bleeding vessel and associated severe hemorrhage. If the rapid and unintelligent application of crushing clamps is applied to the bleeding area, very often more damage is done to the vessel, in addition to possible trauma of contiguous vital structures. This factor of further injury with clamps is particularly applicable to injured vessels in the chest; however, in any area of dissection where large arteries or veins are injured, this situation occurs.

It is far easier and wiser to control the often frightening hemorrhage with pressure, and this is best exerted through the fingers. An index finger will often control the bleeding adequately, or the vessel wall can be approximated with the thumb, the index and second fingers. If the latter maneuver controls the hemorrhage, usually all that is needed is the proximal application of a soft clamp, such as the Satinsky instrument which is so often used in cardiovascular surgery. Such an instrument can easily effect a dry field and allow exact repair of the injured vessel with an arterial suture; particularly is this important when the vessel cannot be sacrificed. Apt examples here would be the inferior vena cava and aorta, as well as the major pulmonary arteries and veins. Such clamps should be universally available in all major thoracic and abdominal surgery, and wherever else in dissection there is the remote possibility of damage to one of the great vessels. In addition, 5-0 or 4-0 *arterial silk* should also be available. Frequently the Allis clamps will prove to be invaluable insofar as their ability to demonstrate without further damage the edges of injured vessels, in order that a soft clamp such as a Satinsky can be applied.

Just recently in the author's experience two ties were pulled off the left main pulmonary artery following a pneumonectomy for carcinoma. This occurred during a node dissection deep in the mediastinum. The only possible way to control the bleeding from this very large vessel stump, which had retracted into the mediastinum, was with the index finger following the stream of blood directly into the main pulmonary artery. Still, bleeding occurred around the finger. Using Allis clamps to take up the slack on the redundant vessel's fit about the base of the left index finger, the bleeding was finally

controlled. Then with application of Allis clamps to the vessel wall on the other side of the finger it was possible to demonstrate the stump of the left pulmonary artery, to gradually withdraw the index finger of the left hand, and to apply a Satinsky clamp with the loss of relatively little blood. The vessel walls were then approximated using arterial silk. Also, recently doing a pneumonectomy (radical) a small rent occurred in the left main pulmonary artery fairly close to its bifurcation with the right pulmonary artery. The quick application of a Satinsky clamp below this rent prevented any bleeding, and we were able to oversew the vessel in a satisfactory fashion, using arterial silk again. An ordinary over-and-over continuous suture was used in approximating the vessel walls in a hemostatic fashion.

Certainly the best way to avoid emergency management of hemorrhage is by the use of proper dissection techniques. However, even when one is most careful, he may well be faced with one of the previously described emergency situations. Just a few of the familiar maneuvers could be described. In dissecting out structures in the gastrohepatic ligament in preparation for a routine cholecystectomy, the surgeon should be cognizant of the possibility of hemorrhage here and ought to have identified and examined the Foramen of Winslow and palpated the right hepatic artery. It is a relatively simple matter to insert the left index finger through the Foramen of Winslow, compress the right hepatic artery, and control hemorrhage from an injured cystic artery in this area of dissection. It is then quite easy, as pressure is periodically released from this hepatic artery, to accurately identify, clamp, and ligate the bleeding vessel. Again, in dissecting vessels of a larger magnitude, such as the pulmonary artery and large pulmonary veins, as well as any of the larger vessels in both peripheral and abdominal surgery, the vessel wall should be identified and the peri-adventitial structures separated directly from this before proceeding further in the isolation of the vessel. The plane of the vessel itself should be obtained before doing any perivascular dissection. It is best not to attempt to isolate a vessel of large magnitude in a rapid fashion by the use of a right angle clamp or some similar instrument—certainly not until the vessel wall has been completely freed on at least three sides. Again, one may be confronted with firm, densely adherent lymph nodes in the bifurcations of vessels, and it is unwise to try to demonstrate the entire

vessel wall in this instance using blunt dissection; but rather one should use sharp dissection to extend the cleavage plane, tending to dissect on the nodal structures rather than the vessel. Frequently it may be necessary before approaching the definitive point of the dissection to isolate the vessels above and below this area, in case compression in these regions may be necessary. In doing any type of pulmonary resection, prior to the approach of great vessels in the hilar region, the lung itself should have been dissected free from parietal and mediastinal adhesions. It is relatively easy to control major hemorrhage by grasping the hilar region with the fingers. Perhaps the most obvious and simple of all principles to remember is that one should never dissect in a small hole wherever there is the possibility of injury to large vessels, instead the surgeon should proceed on a broad front, if at all possible.

Do not be too quick with the application of the usual hemostats to a briskly bleeding area, but remember that the steady and sure application of pressure with the fingers and/or a gauze sponge will often control major hemorrhage and allow the surgeon to collect his wits, properly use Allis and/or Satinsky clamps, and manage a difficult situation in an acceptable fashion.

Head and Heart

A SIMPLE, UNEDUCATED patient once told the writer that everybody he knew liked Dr. X better than Dr. Y because, although Dr. Y seemed to have more knowledge and more skill, Dr. X treated people "from his heart," while Dr. Y treated people "from his head." This was his way of saying that people

like a doctor who is kind, friendly, warm, and sympathetic—who gives his patients, in addition to medicines and instructions, something of himself.

Much is written about psychosomatic medicine, but a very old, very wise, and very successful physician once told the writer that there is no other kind of medicine. The mature and experienced doctor knows that his patient wants more from him than scientifically sound medical advice. The good doctor senses the patient's need to have his emotional problems understood and does not shrink from giving him the reassurance and emotional support he needs.

Psychiatrists tell us that the emotional dependence of the patient on his doctor is like a little child's dependence on his parents. No child wants his parents to be formal, distant, cold, scientific, and unfeeling. The patient greatly over-estimates his doctor's knowledge and therapeutic ability. He feels that the doctor has the power to restore him to health or to let him die—that his fate literally lies in his doctor's hands. In addition to needing complete confidence in his doctor's knowledge and skill, the patient needs to feel that his doctor cares whether he gets well or not. He wants his doctor to care about him as a person; it is not enough for him to feel that his doctor cares about him as a case or a statistic.

Much has been said and written about the poor public relations of the medical profession and what can be done to improve them, but we believe there is one simple answer to the problem. If doctors can learn to like their patients as people and accept honestly their responsibility to give them the emotional support they need, there can be no public relations problem. The doctor must accept his psychological role of "loving parent." If we learn to treat our patients "from our hearts" as well as "from our heads," we need never fear bad public relations or socialized medicine.

Food Storing by Irradiation

LARGE-SCALE IRRADIATION of foods and biologic tissues—for sterilization and storage without refrigeration—will become practicable by 1962.

This was predicted by Dr. T. E. Friedmann, U. S. Army Nutrition Laboratory, at a symposium on food irradiation.

To date, 100 basic food items have already been successfully processed by gamma radiation and have been cleared for toxicity by the Surgeon General, Dr. Friedmann stated.

Future implications of this most modern of food preserving methods, he indicated, are vast. Following irradiation, food can be kept longer—often at

room temperatures. Irradiated fresh pork, for example, has been held on the shelf for as long as six months without spoiling. The keeping quality of highly perishable seafood, like oysters, is also improved by such processing.

Four generations of rats, raised exclusively on such irradiated foods, appeared none the worse for their experience, according to Dr. Luther B. Richardson, Texas Agricultural Experimental Stations.

Human volunteers given diets containing some irradiated food for one-month periods, also apparently suffered no ill effects, Dr. M. S. Read, Fitzsimons Army Hospital, disclosed.

Surgery for Congenital Heart Disease

MANUEL N. COOPER, M.D., Atlanta, Ga.

PHYSICIANS SHOULD TAKE NOTE that surgery for congenital heart disease is living up to its bright promise. Reports from all medical centers show that the operative mortality for established procedures is dropping, and that the indications for palliative and corrective procedures are being carefully extended. Furthermore, it is becoming apparent that the surgical ideal of correction rather than palliation is attainable in many instances, and the enthusiasm of surgeons for these goals should be admired and encouraged.

In one type of congenital heart disease, the *patent ductus arteriosus*, it has long been possible to effect a normal circulation by surgical intervention. The simplicity of the surgical and mechanical principles involved contributed to its early success. Excellent, if not *normal* circulatory effects have been accomplished surgically in other congenital malformations of the great vessels, namely, *coarctation of the aorta*, *pulmonary arteriovenous fistula*, and *anomalies of the aortic arch*. Excellent results have also been obtained in *pulmonic stenosis*, a lesion which from standpoint of surgical attack has been primarily "arterial" in nature.

In the above procedures the necessary pumping action of the heart is not hindered, and circulating blood in the chambers is no deterrent to adequate surgery. In other lesions, however, such as uncomplicated septal defects, surgery is not easily and effectively done by extracardiac attack.

Open cardiectomy, therefore, making possible repair of defects under direct vision, is something of a milestone in chest surgery. For such an approach the right heart must be rendered bloodless, and arrangements must be made to supply the aorta with an adequate load of oxygenated blood. To accom-

plish this, a mechanical pump-oxygenator, or "artificial heart," is employed; this machine receives venous blood from the cavae and the coronary sinus, oxygenates this blood, and presents it under pumping pressure to the systemic circulation. With the human heart temporarily relieved of its load, the surgeon is given two essentials for good repair: time and vision.

With this approach, defects formerly only palliative may now be corrective.

The operations devised for the *Tetralogy of Fallot* will illustrate the physiological differences between palliation and correction. The principle of the older technique is the creation of an artificial ductus arteriosus to return to the pulmonary circuit blood denied entrance and shunted away; an additional defect is created, but the results are palliative. In the newer open cardiectomy technique, the ventricular wall is repaired, the pulmonary artery opened, and an approximately normal circulation restored.

Good surgery makes good diagnosis mandatory.

It is no longer sufficient to diagnose "probable septal defect" or "probable pulmonic stenosis." Every attempt should be made to know as accurately as possible the nature and extent of the lesion, and for this purpose clinical observation must be assisted by electrocardiography, radiology, and cardiac catheterization.

It is to be expected that certain more complex lesions will be corrective as experience is gained, and as laboratory experimentation points the way. The worst forms of congenital heart disease produce death in early infancy, an age when pre-mortem diagnosis is extremely difficult. The present promise of surgery should stimulate a search for better diagnostic techniques.

Prepared at the request of the Committee on Professional Education
of the Georgia Heart Association.



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January and his associates¹ have written on the use of tetracycline (ACHROMYCIN) to treat 118 patients having various infections, most of them respiratory, including acute pharyngitis and tonsillitis, otitis media, sinusitis, acute and chronic bronchitis, asthmatic bronchitis, bronchiectasis, bronchial pneumonia, and lobar pneumonia. Response was judged good or satisfactory in more than 84% of the total cases.

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¹January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.



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Books Received

Laughlin, Henry P., M.D., *The Neuroses in Clinical Practice*, W. B. Saunders Company, Philadelphia, 1956, 802 pp., \$12.50.

Bland, John H., M.D., *Clinical Recognition and Management of Disturbances of Body Fluids*, second edition, W. B. Saunders Company, Philadelphia, 1956, 552 pp., 109 figs., \$11.50.

Wolff, Louis, M.D., *Electrocardiography, Fundamentals and Clinical Application*, second edition, W. B. Saunders Company, Philadelphia, 1956, 342 pp., 199 figs., \$7.00.

Guyton, Arthur C., M.D., *Textbook of Medical Physiology*, W. B. Saunders Company, Philadelphia, 1956, 1030 pp., 577 figs., \$13.50.

Conn, Howard F., M.D. (Editor), *Current Therapy 1956, Latest Approved Methods of Treatment for the Practicing Physician*, W. B. Saunders Company, Philadelphia, 1956, 632 pp., \$11.00.

Davis, Loyal, M. D. (Editor), *Christopher's Textbook of Surgery*, sixth edition, W. B. Saunders Company, Philadelphia, 1956, 1484 pp., 716 figs., \$15.50.

Duncan, Garfield G., M.D., *A Modern Pilgrim's Progress for Diabetics*, W. B. Saunders Company, Philadelphia, 1956, 222 pp., \$2.50.

Hinshaw, H. Corwin, M.D., Ph.D., and L. Henry Garland, M.B., B.Ch., *Diseases of the Chest*, W. B. Saunders Company, Philadelphia, 1956, 727 pp., 277 figs., \$15.00.

Spector, William S. (Editor), *Handbook of Toxicology*, Volume 1, W. B. Saunders Company, Philadelphia, 1956, 963 pp., 173 illustrations, \$13.00.

Sternberg, Thomas H., M.D., and Victor D. Newcomer, M.D., *Therapy of Fungus Diseases*, Little, Brown and Company, Boston, 1955, 337 pp., \$7.50.

Campbell and Liberman, *Physician's Federal Income Tax Guide, 1956 Edition*, Channel Press, Great Neck, N. Y., 1956, \$2.50.

Cameron, Charles S., M.D., *The Truth About Cancer*, Prentice-Hall, Inc., Englewood Cliffs, N. J., 1956, 268 pp., \$4.95.

Wolstenholme, G. E. W.; Margaret P. Cameron and Cecelia M. O'Connor, *Experimental Tuberculosis—Bacillus and Host* (Ciba Foundation Symposium), Little, Brown and Company, Boston, 1955, 396 pp., \$9.00.

Reviews

Koskowski, W., M.D., *THE HABIT OF TOBACCO SMOKING*, John de Graff, Inc., New York, 1955, 292 pp., \$5.00.

Because current medical research has discovered a relationship between certain diseases and the smoking of tobacco, especially in cigarette form, this book is particularly timely and should be of extreme interest to the modern layman as well as the physician. For the layman, a readable and interesting account is given tracing the history of tobacco, from its effects on sociological, religious, and literary developments through the ages, to the effect of tobacco on the human organism from a medical viewpoint and the inevitable conclusion: that there is no benefit to be derived from tobacco smoking; for the physician, an objective and precise report based on modern medical research on the chemical composition of tobacco and its action on the anatomy of man and animals.

The study is divided into two parts. In brief, Part I delves into the historical background and "birth" of tobacco, a detailed world-wide survey showing the use of tobacco and its spread from primitive to civilized societies. Techniques of smoking are discussed at some length and illustrations are used. In Part 2, the author, with a generous use of case histories and illustrative comparative tables of analysis, devotes his study primarily to the scientific approach in the use of tobacco and its role in human life. This is prefaced by a section on the revelation in the nineteenth century of tobacco as a fraud for treatment of disease. Scientific investigation in this period disproved all claims made in earlier years—as far back as the first and second centuries when the plant was discovered—that tobacco was a cure for many ills. Special attention is given also to the constituents of tobacco and tobacco smoke and their relation to anatomical deterioration. The relationship of smoking and malignant tumors is discussed at length with the aid of the latest clinical discoveries in cancer research.

With an appended bibliography and an index, this book is an excellent reference for all physicians and is a ready source for answers to questions raised by patients on the effects of smoking. *The Habit of Tobacco Smoking* is extremely well written and leaves no doubt in the reader's mind as to the overwhelming undesirability of the cigarette habit.

Lam, Conrad R., M.D. (Editor), *HENRY FORD HOSPITAL INTERNATIONAL SYMPOSIUM ON CARDIOVASCULAR SURGERY; studies in Physiology, Diagnosis and Techniques*. W. B. Saunders Company, Philadelphia, 1955, 543 pp., \$12.75.

Cardiovascular Surgery is the most recent compilation of the diagnostic, physiologic, pathologic, and therapeutic approaches to the problems of congenital and acquired heart disease and to those diseases of the great vessels. Conrad Lam, Surgeon-in-Charge, Division of Thoracic Surgery, Henry Ford Hospital, as chairman, with his committee, composed of John H. Keyes, D. E. Szilagyi, R. F. Ziegler, Richard J. Bing, Michael E. DeBakey, Stanley Gibson, and Emile Holman, brought together the greats and near greats of this fascinating and rapidly developing surgical field at a special conference in March 1955.

In an orderly and concise fashion amplified with superb illustrations such authorities as Helen B. Taussig, Charles P. Bailey, Sir Russell Brock, Charles A. Hufnagel, Dwight E. Harken, Michael E. DeBakey, Richard J. Bing, Irvine H. Page, Walton Lillehei, and many others presented their concepts in the interpretation and management of cases which occur in their particular spheres of endeavor.

Despite its title, *Cardiovascular Surgery* should prove as appealing and informative to the practitioner and cardiologist as to the surgeon. It will be a welcome addition to the bookshelf of all doctors who desire the very best treatment for their patients with heart disease.

Robert H. Vaughan, M.D.

Cleckley, Hervey, M.D., *THE MASK OF SANITY*, The C. V. Mosby Company, St. Louis, 1955, 596 pp., \$9.50.

Fifteen years after publication of the first edition, this book remains the most outstanding contribution to the study of psychopathy. Modernized and further enlarged, it is an imposing work.

No statement is made as to what group of readers the author had in mind. Actually, it is implicitly apparent that the book is intended for all interested people, legal, medical, sociological, anthropological, etc. Very little psychiatric knowledge is needed to comprehend this treatise; psychiatric nomenclature is avoided except for a few very basic terms such as regression, transference, etc.

There are five sections to the book. The first is an outline of the problem. Here the non-clinical psychotic manifestations of the culture are discussed and soft-pedalled; the high incidence of psychopathy is estimated; and the observation is made that the disease is seen clearly in the ordinary social situation only, not in the consultation room and hospital.

Section Two is a presentation in some detail of the case histories (13, as compared to nine in the

first edition—now including females). This is by far the best section of the book. The author presents his material extremely well and shows his considerable capacity as a novelist (or biographer). His non-psychiatric vocabulary commands respect, descriptions are colorful and poignant. Example (opening of Chapter 12, case history of Anna): "There was nothing spectacular about her, but when she came into the office you felt that she merited the attention she at once obtained. She was, you could say without straining a point, rather good-looking, but she was not nearly as good-looking as most women would have to be to make a comparable impression."

Section Three, entitled "Cataloging The Material," deals with conceptual confusions and their clarification. This is followed by a rather lengthy discussion of differential diagnosis, which the physician interested in psychiatry should find excellent reading (and the experienced psychiatrist might wish to skip). In the last part of the third section, various characteristics of the psychopath are discussed in detail, each in a separate chapter. It is noteworthy that one of the outstanding traits, well described elsewhere, is omitted: The ability of the psychopath to maneuver others (including psychiatrists) in spite of the latter's conscious awareness of this phenomenon.

Section Four considers first the question, "What is wrong with these patients?" (in 43 pages, compared to 17 in the first edition), then, "Etiological Considerations" (45 pages as compared to 12 in the first edition.)

The fifth section is entitled "What Can Be Done?" In 1955 the answer commands 32 pages (only nine in 1940). Comparative figures are given by this reviewer to illustrate progress, of which they appear to be genuinely representative.

Psychopathy is repeatedly compared to schizophrenia, with which it apparently has much in common. There has apparently been no intensive study of parents of psychopaths, schizophrenic siblings, etc.

On the last page of the first edition is found an appeal for a more thorough study and appraisal of the psychopath; the third edition indicates that this has been answered. In addition, the author has apparently become less hopeless about psychopaths. In this edition there is no mention of the following (from first edition): unmodifiable lack of insight, lack of capacity for real transference, and lack of desire to get well. There is also no mention of the idea of sending all psychopaths to an uninhabited island.

Richard E. Felder, M.D.

The books listed on the opposite page have been received and are hereby acknowledged. This listing should be a sufficient return for the courtesy of the sender. Books ap-

pearing to be of unusual interest will be reviewed as space permits.

THE EDITOR

abstracts by georgia authors



Witham, A. Calhoun, and Robert P. Coggins, Medical College of Georgia, Augusta, Ga. "An Electrocardiographic Technique for Mass Surveys," *AM. HEART J.*, 51:199-210 (Feb) 1956.

A rapid technique for obtaining two limb and two precordial leads is described. As many as 40 electrocardiograms can be taken per hour. The speed depends principally upon the use of special plastic snap-on limb electrodes and elimination of electrode jelly. Detailed criteria for analyzing these tracings is presented. The difference in accuracy between the routine 12 lead electrocardiographic system and the four lead system was negligible in a selected series of 50 normal subjects and 100 cardiacs. Discrepancies in diagnosis did not always favor the twelve lead electrocardiogram. A similar four lead system consisting of V_1 , V_5 , I, and aVF seemed to be equally as good as 12 lead in the diagnosis of 100 selected arrhythmias. A three lead system (I, aVF, and an anterior V lead) showed 10 per cent disagreement with the specific 12 lead diagnosis but failed to identify as abnormal only seven per cent of abnormal electrocardiograms in the same series. These methods have proven successful in cardiac surveys.

Greenblatt, Robert B., Nicanor Carmona, and William S. Hagler, Medical College of Georgia, Augusta, Ga. "Chiari-Frommel Syndrome," *OBST. & GYNEC.* 7:165-170 (Feb) 1956.

Chiari-Frommel syndrome is characterized by galactorrhea, amenorrhea, and pituitary dysfunction, usually occurring postpartum and frequently associated with pituitary tumor. Two cases are presented, and in both the evidence strongly suggests an imbalance in pituitary activity resulting in the unopposed production of an excessive amount of lactogenic hormone responsible for the syndrome. Although large doses of cyclic estrogen-progesterone therapy yield some improvement, no completely satisfactory mode of therapy has been found. Hydrocortisone was tried with a view toward restoring better balance of pituitary secretion, but it proved of no value.

Findley, Thomas, Medical College of Georgia, Augusta, Ga. "Two Kinds of Renal Hypertension," *AM. J. M. SC.* 231:121-124 (Feb) 1956.

Pressor material of renal origin is more easily found in the blood of subjects with circulatory failure than it is in those with hypertension. Since hypertension is only rarely relieved by uni-nephrectomy, *hyper-renalism* is an infrequent cause. Bilateral nephrectomy raises the blood pressure of animals whose lives are prolonged by artificial means so *hypo-renalism* is a second variety. Because reduced renal mass is followed by proliferation of the eosinophils in the anterior pituitary and because the kidneys of patients with essential hypertension handle salt and water in a Cushingoid manner it is suggested that a commoner

cause of hypertension is failure of the kidney tubule to elaborate a material which inhibits the anterior pituitary-adrenocortical axis.

Greenblatt, Robert B., Nicanor Carmona, and Leon Higdon, Medical College of Georgia, Augusta, Ga. "Gonadal Dysgenesis with Androgenic Manifestations in the Tall Eunuchoid Female," *J. CLIN. ENDOCRINOL. & METAB.* 16:235-240 (Feb) 1956.

A syndrome is reported which is characterized by rudimentary ovaries, infantile uterus, complete lack of breast development, moderate amounts of sexual and axillary hair, tall stature, clitoral hypertrophy, a female sex chromatin pattern in the skin, normal to slightly elevated urinary FSH, low urinary 17-ketosteroids, and clinical manifestations of hypogonadism. This case may furnish a link in the relationship between simple ovarian agenesis and ovarian dysgenesis with masculine manifestations. The syndrome should be considered a variant of the syndrome of ovarian agenesis and perhaps a subform of hermaphroditism, and should be differentiated from the various types of heterosexual development.

Henderson, John M., C. D. C., Public Health Service, Savannah, Ga. "Water Management Planning for Malaria Prevention in the Damodar Valley, India," *AM. J. TROP. MED.* 4:1091-1102. (Nov) 1955.

The current and proposed plan of development of the Damodar Valley Corporation, often referred to as India's T.V.A., is outlined. Malaria survey results are reported for the pre-development stage. Recommendations which were made toward malaria prevention in the vicinities of six artificial impoundments and in a million acre area to be irrigated are described. The malarigenic importance of the irrigation development is considered to be far greater than that of the reservoirs. Two conflicting opinions as to the measures which should be undertaken to curb "irrigation malaria" in this particular area, are presented, and a proposal for field research in anopheline ecology is described. The objectives of this research are to evaluate the potential problem and to provide a basis for developing appropriate counter-measures.

Hurst, J. Willis and Henry R. Cooper, Emory University, Ga. "Neoplastic Diseases of the Heart," *AM. HEART J.* 50:782-802 (Nov.) 1955.

Cardiac lesions are found at autopsy in 20 per cent of the patients dying of malignancy and can be diagnosed clinically in about five to 10 per cent of such patients.

Neoplastic involvement of the endocardium may cause no symptoms, but symptoms may occur because of obstruction to the mitral valve, pulmonary veins, tricuspid valve, and superior and inferior vena cava. The patient's symptoms and signs may simulate rheumatic mitral stenosis, ball-valve blockade of the mitral or tri-

cuspid valve, rheumatic tricuspid stenosis, and constrictive pericarditis.

Extensive metastatic neoplastic involvement of the myocardium may produce congestive heart failure. Small lesions in the myocardium produce arrhythmias and various electrocardiographic abnormalities.

Neoplastic involvement of the pericardium must always be considered when the symptoms, signs, and electrocardiographic abnormalities characteristic of pericardial disease make their appearance in a patient with a malignancy. Acute pericarditis, pericardial effusion, and constrictive pericarditis can be the result of primary and secondary neoplasms.

All types of cardiac arrhythmias have been reported to occur in cases of primary and secondary neoplastic disease of the heart, and nonspecific electrocardiographic abnormalities are common in patients with neoplastic disease of the heart.

The x-ray findings of neoplastic disease of the heart have been listed, and several indications for angiocardigraphy have been emphasized.

Some intracavitary cardiac tumors can be removed (i.e., myxoma of the left atrium). X-ray therapy may offer transient benefit in some cases. The surgical production of a pleuropericardial window of pericardial resection is considered the treatment of choice for massive hemorrhagic pericardial effusion that reaccumulates rapidly.

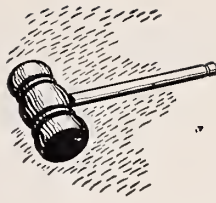
Bartholomew, R. A.; E. D. Colvin; William H. Grimes; John S. Fish; and William M. Lester, Georgia Baptist Hospital, Atlanta, Ga. "Repeat Cesarean Section," *OBST. & GYNEC.* 7:137-144 (Feb.) 1956.

A review of 162 consecutive repeat cesareans performed in the private practice of an obstetric group was undertaken. The indications for the initial sections were judged to be nonvalid in 21 per cent.

Among the sequelae of the initial sections, imperfect healing of the scar was the most serious. Rupture of the scar occurred during late pregnancy in seven (4.3 per cent); imminent rupture in three (1.8 per cent), and potential rupture in six (3.7 per cent). In the latter cases, had labor been allowed rupture of the scar would probably have occurred. There was no maternal mortality. Post operative adhesions were found in 62 per cent.

Notwithstanding far less pregnancy pathology in the repeat than in the initial section cases, term neonatal and stillbirth rates (3.2 and 1.3 per cent, respectively) were practically identical, due mainly to uterine rupture in the former.

Conscientious competent consultation should precede initial sections. The low segment operation lessens maternal and fetal risks in future pregnancies. Only in specialized hospitals, with constant availability of operating room, blood, and attendants, can maternal (but not fetal) risks be lessened in attempted pelvic delivery.



president's page

ATTENDANCE AT TWO MEETINGS of the Council of the MAG was sufficient to inform me that I was ignorant of most of the problems facing our Association.

To help our Association to achieve its aims every member of it must be interested in and informed about these problems and must be willing to help actively and unselfishly to solve these problems in an equitable manner for the good of all.

The corporate practice of medicine by our medical schools is one of the problems. Smouldering but apt to flare up at any time is the question of anesthesiologists, pathologists, roentgenologists, and the other physicians' being salaried employees of institutions. Insurance problems are arising and are still unsettled. Acute in some areas are questions concerning the prerogatives, responsibilities and authority of hospital administrators and the medical staffs of institutions.

Most important and affecting every one of us is the fact that there is no established interpretation of the Code of Ethics of the AMA.

None of us are free from the habit of misinterpreting truth. When we meet reality which doesn't suit our needs and desires we, being human, are apt to ignore it or to lie to ourselves about it. This failure to meet the truth, if carried far enough, produces in individuals what is commonly termed a psychoneurosis. Organizations can suffer from a neurosis in the same manner and differences of opinion about the interpretation of the above problems

are producing difficulties, ill will, and, in some cases, venomous animosity between our members or between our medical organizations and institutions. This situation is bad for institutions, bad for doctors, for our medical organizations and bad for public relations. Any dissent among ourselves is immediately magnified and utilized by columnists and by politicians who wish to make our profession captive to state medicine.

At present we are getting little help from the AMA. The officials are interested but they are moving slowly and cautiously. This is the proper way of procedure but it leaves us no alternative. Each state society and each component society must decide on a definite interpretation of the Code of Ethics and then follow this interpretation. The best way to get rid of a bad rule is to enforce it. If our interpretation proves bad, improper or unworkable, we must be willing to change it, but, let us not tolerate from anybody the breaking of an accepted rule made for the good of the whole.

Medicine, as does all else, undergoes stages of evolution. We can't stop evolution and we can't hurry it too much, but we can guide the evolution in medicine along a path better than the one it is following.

During the coming months I shall endeavor, through the President's Page, to give you an analysis of what is happening over the United States concerning the medical profession and its problems.

Hal M. Watson.

Executive Committee of Council

March 18, 1956, Savannah

THE EXECUTIVE COMMITTEE OF COUNCIL met on Sunday, March 18, in the Whitmarsh Room, General Oglethorpe Hotel.

Present were: H. Dawson Allen, J. W. Chambers, Hal M. Davison, and the Messrs. Krueger and Kiser.

Three representatives of the Medical Association of Georgia were appointed to serve on the Hospital Care Study Commission which was recently set up by the Georgia General Assembly. They are William Harbin,

Rome; Virgil B. Williams, Griffin, and Milford B. Hatcher, Macon.

The committee appointed two representatives to serve with two representatives of the Georgia Board of Medical Examiners on a committee to consider the revision of the entire Medical Practice Act of Georgia. Appointed were: David Henry Poer, Atlanta, and Enoch Callaway, LaGrange. Dr. Davison was made an *ex-officio* member of this committee, and Tom Ross, Macon, was appointed alternate.

Next item of business concerned the appointment of three physicians to serve on a druggists-doctors-dentists liaison committee. Appointees are Chris J. McLoughlin, Atlanta; John F. Stegeman, Athens, and Maurice F. Arnold, Hawkinsville.

The next meeting of the Executive Committee will be held at 4:30 p.m., Thursday, April 12, in the MAG Headquarters Office.

There being no further business, the meeting was adjourned.

New Members

Name	Address	Classification	County
John Hamilton Angell	126 E. Taylor St., Savannah	Active	Ga. Med.
Stevan M. Carroll, Jr.	304 Cherokee St., Marietta	Active	Cobb
Lige Moultrie DuBose	1205 Roswell St., Marietta	Active	Cobb
James William Garner	Austell Hospital, Austell	Active	Cobb
Henry Cameron Gormon	119 S. Atlanta St., Smyrna	Active	Cobb
Robert Taylor Klingbeil	2539 Roswell Rd., Marietta	Active	Cobb
Edgar Allen Vaughan	304 Cherokee St., Marietta	Active	Cobb
Frederick D. Cheney	24 W. Central, Moultrie	Active	Colquitt
James H. Jenkins	The Harbin Cline, Rome	Active	Floyd
Coleman Taylor King	Bathey State Hospital, Rome	Active	Floyd
Nim J. Guthrie	384 Peachtree St., N.E., Atlanta 8	Active	Fulton
Judson Louis Hawk, Jr.	27 8th St., N.E., Atlanta 9	Active	Fulton
Dan Bruce Kahle	3254 Peachtree Rd., N.E., Atlanta 5	Active	Fulton
James Walter Lea, Jr.	Emory University Hosp., E. Univ.	Associate	Fulton
R. Waldo Moore, Jr.	Emory University Hosp., E. Univ.	Associate	Fulton
Robert Neil Poole	340 Blvd., N.E., Atlanta 12	Active	Fulton
George H. Preston	Fulton County Health Dept., Atlanta	Associate	Fulton
Sidney Levingston Sellers	35 Linden Ave., N.E., Atlanta 8	Associate	Fulton
Willam Charles Wansker	5998 Peachtre Rd., N.E., Atlanta 19	Associate	Fulton
Robert James Hooper	745 Pine St., Macon	Active	Muscogee
Charles M. Ward	107½ Lee St., Dawson	Active	Randolph-Terrell
W. A. Mason	116½ N. Ashley St., Valdosta	Active	S. Ga.
Thomas H. Moseley	1306 N. Patterson, Valdosta	Active	S. Ga.
Thomas C. Dickinson	Soperton	Active	S. E. Ga.
Robert Carter	Thomaston	Active	Upson

ANNOUNCEMENTS

National Society for Crippled Children and Adults Annual Convention—Hotel Statler, Washington, D. C., October 28-31, 1956. Formal sessions in the mornings and workshops, seminars, and institutes covering many phases of rehabilitation in the afternoons. For further information, write to the National Society for Crippled Children and Adults, 11 S. LaSalle St., Chicago 3, Ill.

American Institute of Dental Medicine Annual Meeting—El Mirador, Palm Springs, Calif., Nov. 4 to 8, 1956. Meeting will feature lectures and round table forums. Applications and full information may be secured from the Executive Secretary, Miss Marion G. Lewis, 2240 Channing Way, Berkeley 4, Calif.

Georgia Heart Association Eighth Annual Meeting and Scientific Session—General Oglethorpe Hotel, Savannah, Ga., September 14-15, 1956. Programs will be mailed to all Georgia physicians.

American Congress of Physical Medicine and Rehabilitation 34th Annual Scientific and Clinical Session—The Ambassador, Atlantic City, N. J., Sept. 9-14, 1956. All sessions open to AMA members. Full information may be obtained from the Executive Secretary, Dorothea C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Ave., Chicago 2, Ill.

DEATHS

CHRIS H. PINSON, Atlanta, died April 9, 1956, at the age of 74.

A native of Geiger, Alabama, Dr. Pinson had practiced in Atlanta for 31 years before his retirement 11 years ago. He was a graduate of Memphis Hospital Medical College in Tennessee.

Dr. Pinson was a member of Trinity Methodist Church and of the Fulton County Medical Society.

Funeral services were held at Spring Hill on April 11th, with burial

in Westview Cemetery in Atlanta.

Survivors include his wife; a daughter, Mrs. Fred H. Hall of Bethesda, Md.; a sister and two brothers.

GEORGE MARTIN WHITE, Rockmart, died on April 11, 1956. He was 77 years of age.

Dr. White was a native of Haralson County and was educated at Emory College. He received his M.D. degree from the Atlanta College of Physicians and Surgeons in 1906 and began practice in Buchanan that same year. He moved to Rockmart in 1910.

He was a Shriner, a director of the Rockmart Bank and charter member of the Rockmart Rotary Club. He had served as president of the Polk County Medical Society. Dr. White was the first chief of staff at the Rockmart-Aragon Hospital when it was opened in 1953.

Funeral services were held on April 12, 1956, at the First Methodist Church in Rockmart, with burial in Rose Hill Cemetery.

Surviving Dr. White are his wife, the former Miss Anne Calhoun Ferguson; a stepson and a stepdaughter.

BURR THADDEUS WISE, Plains, died April 6, 1956, at his home near Plains. He was 73-years-old.

A native of Plains, he attended the Plains schools and Newberry (S.C.) College. He received his M.D. degree from Tulane University School of Medicine. Dr. Wise was joined in practice by his two brothers, the late S. P. Wise and B. J. Wise, and together they operated the Wise Sanitarium in Plains for many years. The hospital burned 20 years ago, and Dr. Wise became a member of the Americus City Hospital staff and also established Wise Clinic at Americus. He retired from practice in November of 1950 and since then had made his home on a farm near Plains. He was married to Miss Louise Lamar of Columbus who died in 1931.

Dr. Wise was a member of the Plains Lutheran Church, the American College of Surgeons, and for several years was a member of the Georgia State Board of Medical Examiners. He was a past president

of the Americus Kiwanis Club and a member of the Elks' Club, Masons, and Woodmen of the World.

Survivors include three daughters and two sons, one of whom is S. P. Wise, III, M.D., of San Benito, Tex.

Funeral services were held at the Plains Lutheran Church with burial in Lebanon Cemetery, Plains. Members of the Sumter County Medical Society were honorary pallbearers.

SOCIETIES

The SECOND DISTRICT MEDICAL SOCIETY met on April 5, 1956, at Radium Springs. Officers of the society are Marvin B. White, Thomasville, president; H. B. Baxley, Donaldsonville, vice president; and Julian B. Neel, Thomasville, secretary-treasurer. Guest speakers were Thomas Findley, Augusta; W. P. Stoner, Sylvester; and David D. Mennen, Albany. Dr. Findley spoke on the progress which has been made in developing an artificial kidney. Officers elected at the meeting are as follows: W. P. Rhyne, Albany, president; Earl Dupree, Bainbridge, vice president; George R. Dillinger, Thomasville, councilor; and Julian B. Neel, Thomasville, was re-elected secretary-treasurer.

The SIXTH DISTRICT MEDICAL SOCIETY held its spring meeting on April 11, 1956, at the VA Hospital in Dublin. Officers of the society are as follows: John Bell, Dublin, president; Walter Bramblett, Forsyth, vice president; and Herbert Olnick, Macon, secretary-treasurer. participating in the scientific program were the following physicians: William C. Shirley, Macon—"Why Vaginal Hysterectomy?"; James W. Murdoch, Dublin—"A Case of Left Hepatic Lobectomy for Hepatic Carcinoma"; Lovick E. Dickey, Macon—"Fractures in Children"; Robert W. McAllister, Macon—"Vesico-Vaginal Fistula-Repair by Suprapubic Approach"; and Thomas L. Ross, Jr., Macon—"Myocarditis." A social hour and banquet followed the business meeting. At the banquet Peter L. Scardino, Savannah, spoke on "A Case for Social Medicine."

The SEVENTH DISTRICT MEDICAL SOCIETY met on April 4, 1956, at the Coosa Country Club in Rome, for barbecue and a scientific session. The following physicians presented papers: Don Schmidt, Cedartown—"Poisoning in Children"; Lester Harbin, Rome—"Cancer"; James Jen-

kins, Rome—"Functional Uterine Bleeding"; and W. P. Nicolson, Jr., Atlanta—"Breast Lesions." W. U. Hyden, Trion, presided at the semi-annual meeting, and the following officers were installed: Ralph Johnson, Rome, president; G. L. Broadrick, Dalton, president-elect; and Cecil B. Elliott, Cedartown, secretary-treasurer.

The NINTH DISTRICT MEDICAL SOCIETY held its semi-annual meeting on April 18, 1956, at the Canton Golf Club. Participating in the scientific program were the following: Parrish B. Cleveland, Toccoa—"Trilogy in Anesthesia"; Joe B. Neighbors, Athens—"Some Common Pulmonary Problems"; Marvin Sugarman, D.D.S., Atlanta—"The Tongue"; and William R. Chambers, Atlanta—"The First 24 Hours in Head Injury." Following the scientific session, the following officers were installed: W. R. Garner, Gainesville; George T. Nicholson, Cornelia, president-elect; and Robert T. Jones, III, Canton, secretary-treasurer. A social hour was held at the home of Dr. and Mrs. Jones in Canton before dinner at the Pinecrest Inn.

Ross Whatley was host to the BARROW COUNTY MEDICAL SOCIETY on March 11 1956, at Dock Adams. The guest speaker at this meeting was Richard E. Felder, Atlanta, who spoke on psychotherapy.

BIBB COUNTY MEDICAL SOCIETY met on April 3, 1956, at the Pinebrook Inn. The guest speaker was C. R. Stephen, professor of anesthesiology at Duke University, who spoke on "Common Complications of Pediatric Anesthesia."

The CLARKE COUNTY MEDICAL SOCIETY and the Athens-Clarke County Health Department sponsored an all-day diabetic clinic on March 29th and March 30th. The program consisted of a movie, "What is Diabetes?"; a talk by Bolling DuBose and J. B. Neighbors, Athens—"The Problems of a Diabetic"; "The Normal Diet" (talk); and a discussion on "Meal Planning for the Diabetic." Demonstrations and a movie on "Selecting Meals for all Occasions" followed.

FULTON COUNTY MEDICAL SOCIETY met at the Academy of Medicine, Atlanta, on April 5, 1956. William A. Reid, a resident at Grady Memorial Hospital, described a study being made at Grady to determine

the effectiveness, if any, of injections of trypsin into the muscles of patients with thrombophlebitis; Charles E. Dowman presented a paper on "Pain Following Spinal Anesthesia." James T. King traced the history of operations for the removal of tonsils and adenoids.

The GEORGIA MEDICAL SOCIETY met on April 10, 1956 to hear an address by Osler A. Abbott, Atlanta. His topic was "Present Status of Vascular Grafts and Methods of Blood Vessel Reconstruction." The last of the society-sponsored forums was held on April 3, 1956; the topic under discussion was "Living with Cancer." Participating in the discussion were Samuel F. Rosen, speaker; H. L. Schofield, moderator; and Darnell L. Brawner, John G. Zirkle, and Herman Delancy, panelists.

The MUSCOGEE COUNTY MEDICAL SOCIETY met on March 26th to hear an address by Irwin S. Leinbach of St. Petersburg, Fla. He spoke on "Medical Practices in Europe." Dr. Leinbach, an orthopedist, has made seven visits to Central and Southern Europe since World War II and last summer presented a series of lectures at the University of Goettingen in Germany.

C. Ashlev Bird, Jacksonville, Fla., addressed the WARE COUNTY MEDICAL SOCIETY at its meeting in April. He spoke on the newest surgical treatment of Parkinson's Disease and other tremors: anterior choroidal artery ligation, a method developed by Irving Cooper of New York. Dr. Bird was introduced by Arthur M. Knight, Jr., Waycross. Floyd E. Davis, Waycross, president, presided at the meeting held at the Regional Health Office, Waycross.

The WILKES and McDUFFIE COUNTY MEDICAL SOCIETIES held their March meeting in Washington. Following supper, the members heard a talk on tumors of the breast by Val Hastings, Augusta.

PERSONALS

First District

ELLISON R. COOK, III, Savannah, has been named director of the newly established Chatham County Clinic for alcoholism. He was the speaker at the Savannah Post Protestant Ministerial Union on April 2nd, at which time he reviewed the work done by the state clinic in Atlanta and said that the success of the work

in Atlanta has encouraged leaders to establish outpatient clinics. Savannah will have the first such clinic in the state. It will be located in a former church building near the Warren A. Candler Hospital.

J. W. DANIEL, Claxton, celebrated his 86th birthday on March 27, 1956. Several friends and members of his family called during the day.

Dr. and Mrs. J. CURTIS G. HAMES, Claxton, attended the Academy of General Practice's Session on Heart Disease in Washington, D. C., in March. They were guests at a breakfast with the Georgia Representatives and Senators at the Statler Hotel. They also visited the National Health Institute at Bethesda, Md.

JOHN G. ZIRKLE, Savannah, has been made a colonel in the U. S. Army Reserve. He is commanding officer of the 332nd Medical Group, a Savannah Army Reserve unit.

Second District

Dr. and Mrs. E. E. DAVIS, formerly of Meigs, have moved to Pelham to reside. Dr. Davis will continue to practice in the Meigs Medical Clinic, however.

C. A. FLEMING, Tifton, has been appointed medical officer for the U. S. Air Force radar unit at Tifton. At present about 85 men are stationed at the radar unit, and Dr. Fleming will treat all emergency cases from the station.

HENRY K. JARRETT, JR., Tifton, announces the opening of an office with R. E. JONES on Second Street, Tifton, for the practice of urology. Dr. Jarrett graduated in 1947 from Vanderbilt Medical College and comes to Tifton from Macon.

ERNEST F. WAHL, Thomasville, spoke to the Cairo Kiwanis Club at a recent meeting of the club. His topic was heart disease, its causes and treatment. Dr. Wahl was introduced by C. K. SINGLETON, Cairo, program chairman.

R. F. WHEAT, Bainbridge, as chairman of the Decatur County Board of Health and acting Health Commissioner, received the keys to the new Decatur County Board of Health Center at dedication ceremonies held on March 23rd. The dedicatory address was made by T. F. SELLERS, Director of the Georgia Department of Public Health. The center is located at the corner of West and Eva Streets in Bainbridge.

Third District

L. C. CHEVES, JR., and C. P. SAVAGE, Montezuma, are now associated in the practice of medicine and surgery and in the operation of the Riverside Sanatorium. Dr. Cheves had maintained an office downtown for several years before April 1st when he moved his office to the hospital, which was built by Dr. Savage more than 18 years ago.

At a meeting of the Columbus Lawyers Club recently A. B. CONGER, LUTHER H. WOLFF, J. A. ELKINS, W. EDWARD STOREY, and WALTER THWAITE, Columbus, participated in a panel discussion on the attorney-medical expert relationship. The doctors said that most doctors fear the unknown when called into court to testify and that they also feel that time spent in court is wasted. They favored pre-trial conferences in an effort to get the cooperation of all persons involved.

W. G. ELLIOTT, Cuthbert, attended the American Academy of General Practice's Eighth Annual Scientific Assembly held in Washington, D. C.

T. SCHLEY GATEWOOD, Americus, has been elected president of the Dale Carnegie public speaking course class now in progress in Americus.

ROBERT B. MARTIN, III, Cuthbert, spoke to the Cuthbert Lions Club on "Doctors' Day." Dr. Martin, a former president of the local group, explained how Doctors' Day came into being as a result of action by the Woman's Auxiliary to the MAG and its reason for being on March 30th: the anniversary of the first use of ether anesthesia by Crawford W. Long in Jefferson, Ga.

R. B. QUATTLEBAUM, Ft. Gaines, announces the re-opening of his offices for the general practice of medicine and surgery on April 16th in the Clay County Hospital, Ft. Gaines.

JAMES REYNOLDS, Ashburn, announces the re-opening of his offices for the general practice of medicine. Dr. Reynolds is a native of Greensboro and a graduate of Emory University School of Medicine; he interned at St. Louis City Hospital. He completed residency training at Macon Hospital and served in the U. S. Army Medical Corps. Dr. Reynolds is married and has three children, Brent, Brenda, and Kyle.

Fourth District

GRADY E. BLACK, Griffin, has been certified by the American Board of Pediatrics. Dr. Black has been in the practice of pediatrics in Griffin for several years.

R. L. CARTER, Thomaston, after 33 years' practice in Thomaston and three years' cattle farming in Devereaux, has returned to Thomaston to practice general medicine on a limited basis. His offices will be at The Clinic on South Green Street.

A. H. FRYE, JR., Griffin, will be in residency at the Baroness Erlanger Hospital, Chattanooga for the next three years; his office on North Hill Street will be occupied by Samuel C. Johnson of Parsons, West Virginia. Dr. Johnson is a graduate of Cornell Medical School and has had postgraduate training in several New York Hospitals. He and Mrs. Johnson have one daughter.

IVAN B. ROSS, Griffin, spoke to the Griffin-Spalding County Hospital Auxiliary at a meeting held recently. Dr. Ross is the new pathologist at the hospital, and he explained to the auxiliary the advantages of having a resident pathologist in any hospital.

BEN H. JENKINS, Newnan, left the U. S. on April 19th for a visit to the U.S.S.R. to tour Russian hospitals and clinics. He was assigned a Russian interpreter by the government who will accompany him and assist him in his discussions with the Russian physicians. Dr. Jenkins planned to be in Moscow for the traditional May Day celebrations.

Fifth District

CARL C. AVEN, Atlanta, was the principal speaker at the annual meeting of the Bibb County Tuberculosis Association in Macon. Dr. Aven's topic was "Tuberculosis and the Place the TB Association Has in Our Community." The speaker was introduced by SAM E. PATTON, Macon, past president of the local and state associations and a representative on the national board.

EDGAR BOLING, Atlanta, is the new president of the Emory Medical Alumni Association, succeeding C. STEADMAN GLISSON, Atlanta. A. E. HAUCK, Atlanta, was re-elected secretary-treasurer. The officers were elected at the association's annual banquet which concluded an association-sponsored postgraduate medical clinic held April 12 and 13 at Emory.

F. PHINIZY CALHOUN, JR., Atlanta, is one of 12 ophthalmologists throughout the country who will serve on committees to select recipients for the residency fellowships in ophthalmology, recently established by the Guild of Prescription Opticians of America. Dr. Calhoun was elected to serve as vice-president of the Georgia Society of Ophthalmology and Otolaryngology at the spring meeting of the society held at the General Oglethorpe Hotel in Savannah, March 9 and 10, 1956.

MURDOCK EQUEN, Atlanta, addressed the Nashville Academy of Ophthalmology and Otolaryngology at the spring meeting in Nashville on April 16. He spoke on "Cancer of the Larynx."

WILLIAM J. FEDACK, East Point, announces the removal of his office to 318 South Sylvan Road in East Point. Dr. Fedack has practiced medicine in East Point for the last three years.

The American Congress of Physical Medicine and Rehabilitation has announced that HARRIET E. GILLETTE, Atlanta, has been awarded the entire stipend of \$1,000 of the Richard Kovacs Memorial Fellowship Fund. This fund is to help defray expenses of a qualified physician wishing to attend the Second International Congress of Physical Medicine, August 20-24, 1956, at Copenhagen, Denmark.

HARVEY E. GRIGGS, Conyers, attended the American Academy of General Practice's Eighth Annual Scientific Assembly held in Washington, D. C.

J. WILLIS HURST, Emory University, a native of Carrollton, was the guest speaker at a regular meeting of the Carrollton Lions Club. He spoke on the causes and effects of various types of heart disease. Dr. Hurst was introduced by H. L. BARKER, Carrollton.

A. L. MORRIS, Fairburn, attended the American Academy of General Practice's Eighth Annual Scientific Assembly held in Washington, D. C.

George M. Owens, Norcross, has opened offices in the Gearhart Building, Brookhaven, for the practice of General medicine. He is associated in practice with C. A. N. RANKINE, who has been in Brookhaven for several years. Dr. Owens is a graduate of the University of Tennessee

Eighth District

School of Medicine and served his internship and residency in obstetrics and gynecology at Crawford W. Long Memorial Hospital, Atlanta.

The *Journal* in behalf of the members of the Association extends to GEORGE ROACH, JR., Atlanta, and his family, sympathy on the death of his father, Mr. George Roach, on March 29, 1956. Mr. Roach was a former president of Georgia Military College and a former dean of Emory at Oxford.

Small busts of Crawford W. Long made of red Georgia clay will soon be distributed for sale throughout the nation. The first of these was presented to LESTER RUMBLE, JR., Atlanta, by the Jefferson Lions Club in appreciation of his work for the establishment of the Crawford W. Long Museum in Jefferson. Dr. Rumble is chairman of the MAG Crawford W. Long Memorial Committee.

The engagement of Miss Marjorie Padorr, of Chicago, to CHARLES MARVIN SILVERSTEIN, Atlanta, has been announced by her parents. The wedding will be solemnized on May 27th in Chicago.

Sixth District

W. M. BARTON, Macon, was elected president of the Georgia Society of Ophthalmology and Otolaryngology at the spring meeting of the society held at the General Oglethorpe Hotel, Savannah, on March 9 and 10, 1956. He succeeds ALTON V. HALLUM, Atlanta, in that office.

Dr. and Mrs. A. W. BRAMBLETT, Forsyth, attended the American Academy of General Practice's Eighth Annual Scientific Assembly held in Washington, D. C.

The *Journal* in behalf of the Association extends to RICHARD L. SMITH, Cochran, and his family, sympathy on the death of his father, Dr. A. L. Smith in Cochran. Dr. Smith was a graduate of the Atlanta College of Physicians and Surgeons and had practiced medicine in Bleckley and Dodge Counties for more than 50 years.

Seventh District

The *Journal* would like to extend the sympathy of members of the Association to VIRGINIA HAMILTON MALEY, Cartersville, on the death of her husband, Mr. William C. Maley on April 12, 1956.

RICHARD L. BENSON, formerly of Dalton, announces the removal of his offices to Broxton. He will occupy the office in Dr. Lott's former office building. Dr. Benson held open house there on April 7th. A native of Marietta, Dr. Benson moved to Eatonton at an early age and attended public school there; he graduated from Mercer University and the Medical College of Georgia. He was formerly Commissioner of Health with the Dalton-Whitfield Health Department.

G. T. HENDRY, Blackshear, has reached the 50-year mark in the practice of medicine. Dr. Hendry graduated from the Atlanta School of Medicine on April 3, 1906, and came to Blackshear to hang out his shingle in association with his father, the late I. A. Hendry, who at the time had been practicing medicine for 50 years. His diploma, dated 1856, hangs with the younger Dr. Hendry's, dated 1906, in the Hendry Clinic where the present Dr. Hendry is still active in the practice of medicine with his son and daughter-in-law, W. A. and KATHERINE HENDRY.

IVEY JACOBS, Waycross, has been appointed chief of the Ware County Heart Clinic by ARTHUR M. KNIGHT, JR., Waycross, chairman of the clinics committee of the Georgia Heart Association. Dr. Knight, who has served as chief of the clinic since it was established in 1952, will continue to serve on the staff. WILLIAM E. HARDEN is the third physician on the staff.

JOSEPH B. MERCER, Brunswick, was the guest speaker recently at a meeting of the Brunswick Chapter of the Daughters of the American Revolution. He talked on socialized medicine, the opposition by the medical profession, and the disadvantages such a program could have to the individual seeking medical aid. He also discussed the need for expanded rehabilitation program.

Ninth District

BRADLEY DAVIS, Gainesville, was awarded the Ed Dodd Youth Service Award by the Gainesville Kiwanis Club as the highlight of the Ladies' Night program held in March. Mr. Dodd, creator of the Mark Trail comic strip, in presenting the award cited Dr. Davis' 33 years of service as a pediatrician and his activities with the Chamber of Commerce, the Kiwanis Club, the First

Baptist Church, the Boy Scouts, and the Red Cross. March 27th has been proclaimed by the city and county commissions to be Bradley Davis Day, "this year and every year."

SAMUEL H. HAY, Toccoa, spoke to the members of the Toccoa Woman's Club on "Rheumatic Fever" at their regular meeting on March 23.

The Clarksville Doctors Building was officially opened on Monday, April 2, 1956, after open house was held by C. M. HENRY, L. G. HICKS, T. N. LUMSDEN, J. L. WALKER, all of Clarksville, and Mr. J. T. Green, Optometrist, on April 1st. The building is located on Madison Street and adjoins the old Presbyterian Manse which has been in use as the Doctors Building since July 1955.

CULLEN MCCARVER, Gainesville, announces the removal of his office to 107 North Prior Street at the corner of East Broad in Gainesville. WALTER FAUST DURDEN also has his office in this building.

Dr. and Mrs. JOHN SCHREEDER, Chamblee, and Dr. and Mrs. W. K. KERR, Doraville, attended the American Academy of General Practice's Eighth Annual Scientific Assembly held in Washington, D. C. in March.

Tenth District

Edwin Leland Brackney, formerly of the University of Minnesota, has been appointed assistant professor of surgery at the Medical College of Georgia. Dr. Brackney was born in Douglas, Arizona; he received his A.B. degree and his M.D. degree from the University of Minnesota. Since 1949 he has been working there on his Ph.D. degree in surgery. He was also an instructor in surgery. Dr. Brackney served with the U. S. Army Medical Corps from 1947 to 1949 and from 1950 to 1952. Mrs. Brackney is the former Paula Stone of Minneapolis, and they have one son, Brian Leigh Brackney.

HARRY T. HARPER, JR., Augusta, told members of the Sylvania Lions Club recently some of the things to do to avoid having a heart attack, particularly things like watching one's weight.

HOKE WAMMOCK, Augusta, was the guest speaker at a recent meeting of the Augusta Rotary Club; he talked about cancer, and the fact that early detection means early cure was stressed.

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Journal OF THE MEDICAL ASSOCIATION OF GEORGIA

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Journal OF THE MEDICAL ASSOCIATION OF GEORGIA

PRESIDENT'S ADDRESS, 106th Annual Session, Medical Association of Georgia

The Teaching of Medicine— More and More a Full Time Job

H. DAWSON ALLEN, JR., M.D., Milledgeville, Ga.

GOING BACK TO THE Fifteenth Century we find Linacre reducing medicine to a single language and Paracelsus speaking out in his native tongue. Their influence was more in keeping with the rise of the objective humanities of this time rather than the scientific. Paracelsus, however, is credited by some as being the father of chemical pharmacology, although this was mostly in the nature of a protest against the preparation of the Galenicals. He insisted that metals and minerals were mined and purified with greater care than the pharmacists accorded the preparations for treatment of human ills. His contribution to scientific medicine was practically nothing. One of his given names, the only one he retained in assuming a professional name, has given us a word that is always of concern to anyone writing anything like a presidential address: Bombastus is the name, and "bombast," the word. Both Linacre and Paracelsus broke the traditions of their time, releasing medicine from the classical learnings which had become completely static in complete adherence to Galen, as his teaching remained in Greek.

Andreas Vesalius (1514-1564) was born in Belgium, started his studies of anatomy in France, and later was attached to the University of Padua where he produced his seven books on the structure of the human body. He was followed immediately by Fallopius and Frabricius. They established anatomy as a full time professorship and their time as the century of anatomy.

Sir William Harvey (1578-1657) studied under Frabricius between 1598 and 1601, and in 1628 published his studies on the pumping nature of the heart. He was still the anatomist but added function to

structure. This gave birth to experimental medicine and added physiology as a full time study; his time became the century of physiology.

It is interesting to note that Galileo (1564-1642) published his dialogues on two new sciences concurrently (1628) with Harvey's work. Galileo defined science as the answering of questions by operational procedures.

This same year, 1628, records the birth of Malpighi who availed himself of Leeuwenhoek's (1632-1723) recent invention, the microscope, and extended the circulation of the blood through the capillaries and also described the corpuscular nature of the blood.

While it has no special effect on the preclinical subjects of medicine as developed by Vesalius, Harvey and Malpighi, one should pause a moment to consider Sydenham (1624-1689), the founder of medical taxonomy and realize that he antedated Linnaeus (1707-1778) who really put classification on a scientific basis. It should also be mentioned that Sydenham had availed himself of the inventions of Sanctorius (1561-1638) which measured pulse and temperature.

The Eighteenth Century saw mostly a resurgence of clinical medicine until the very end when Bichat (1771-1802) in his very short life extended the work of Malpighi into histo-pathology and subjected the clinical entities of Sydenham and others to postmortem verification. With a smattering of physics, chemistry, and botany mixed with a more thorough study of anatomy and physiology, medical education remained mostly clinical with the clinical preceptor both at home and in college dominant as well as

pragmatic in emphasis, with Latin being retained only for the writing of prescriptions.

The Nineteenth Century produced this array of discoverers, in the order of their births, who interposed themselves between the students and the clinicians with full time preclinical studies: Claude Bernard (1815-1878), Rudolf Virchow (1821-1902), Herman von Helmholtz (1821-1894), Louis Pasteur (1822-1895), and Robert Koch (1843-1910), with Paul Ehrlich (1854-1915) and Wilhelm Konrad von Roentgen (1845-1923) as the transitional discoverers into this century. Thus, the Nineteenth Century can be called the century of histo-pathology plus microbic etiology. Ehrlich starting our present century into the half century of chemo-therapy.

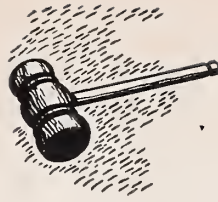
Bernard's biosynthesis of urea and Pasteur's right and left sided crystals of tartaric acid certainly gave a structure to the organic molecule. Koch's chemical staining and reproduction of bacterial disease developed Pasteur's organisms of disease into bacteriology. Virchow extended the verification of specific disease entities by employing tissue staining methods. Helmholtz's approach to the nervous system through the senses revised the concept of sound and light or perhaps more accurately confirmed their undulant nature as opposed to the corpuscular concepts of earlier times. (Odor, flavor and feel may still be corpuscular or combined with undulation as Helmholtz was somewhat forsaken under a Freudian influence.) However, Helmholtz should be considered as having conditioned von Roentgen's mind for discovering and developing the X-ray. I have to stop short of isotopic chemo-therapy as related to von Roentgen. Paul Ehrlich, studying the chemical nature of immunity as demonstrated by Pasteur, hit upon his concept of guided missile therapy.

Our century finds us with not only magic bullets directed at various kinds of bacteria along with replacement therapy such as thyroid, insulin, and estrogens, but also with remedies directed at abstract concepts, such as distraught emotions and psychic inertias, and intellectual distortions, such as delusions, hallucinations, obsessions, and compulsions. These remedies are potent drugs with definite and measurable effects on muscles, blood pressure, and the pyramidal nervous system; and these are just a small part of many other physiological active drugs such as antihistamines, cholinergics, hematinics, sympathomimetics, vagotonics, vice-versa, vasodilators, vasoconstrictors, antipyretics and pyrogenics, analgesics and antifibrotics, new and better hypnotics, and laxatives along with vitamins for all conditions of malnutrition and all periods of life. There are appetite destroyers, useful in fat reduction, and there is also the will power re-enforcer for the control of alcoholism, as well as synthetic opiate substitutes, one at least targeted on spasms, another on pain, a third on cough, and a fourth orally as effective as hypodermic morphia and useful in the reduction treatment of addicts.

Surgery, anesthesia, and medical diagnosis with better techniques and implements have made equal advances, much of the time leading the way. However, most of the progress from basic discoveries met with some opposition from an innate professional attitude, whether medicine or law, that always strives to maintain the state of things as they are. From Linacre to Ehrlich there has been an attitude of *Homo homini lupus* but now we have only *Medicina nusquam non est* with eager acceptance from the profession, the press, and the public. In the olden days and even now, in the remote and sparsely settled rural areas with declining population and aging physicians, we frequently saw and still see physicians not on speaking terms with each other but each greatly beloved by an adherent clique. Now with goodwill towards all we are seemingly losing some of the esteem and affection that we formerly received from our limited following to which we gave ourselves as well as our remedies.

This places us in a critical and dangerous position. Our only hope is to simplify our too rapidly expanding medications. We need a Willard Gibbs (1839-1903) to do for our pharmaco-dynamics what he did to thermo-dynamics, and, as with him, this can best be done in a cloistered academic setting by physicians set apart as teachers and searchers after facts without having too much concern with the business of making a living. The full time clinical professor is with us to stay. He must be supported with well-operated hospitals for his workshop and a forum for instructions. In teaching hospitals, whether publicly or privately supported, the professional fee in keeping with ability to pay for services rendered should be preserved if for no other purpose than to be a measure of prestige.

There is a faint ray of hope that this century may yet be one of ordered chemo-therapy. In an article from a symposium on a recently introduced drug, a French professor proposed with some validating evidence that this drug produces three effects when the methods of administering and the dose varied with the posture of the patient. To illustrate, maximum dose in recumbence gives hibernation, gradually increasing dose in ambulation produces neurolepsy, and moderate doses beginning with two hours recumbence and two hours ambulation produces ataraxis. He was too modest to admit it, but by the way this professor writes I am sure he gave much of himself and interest along with his medicine in making this observation. Adding six variables between dosage and postural state along with professional interest and enthusiasm and inherent recuperativeness to each physiologically active drug now in our armamentarium, we produce an intropy equal to that of trying to shuffle a deck of cards back into four ordinate suits of 13 each, and this is what we seem to be doing without even the aid of extrasensory perception if we do not give full support to our medical faculties without fear of infringement on our private professional prerogatives.



president's page

IT SEEMED WISE to find out what is happening to doctors and to medical organizations in other states before attempting to settle our own problems in what might be a too precipitous manner. Are their problems the same as ours or different from ours? Are there any differences of opinion among the members of our profession concerning these matters? If so, what are these differences and what are they based on? Have medical societies of other states settled any of these problems, and if so, how?

To determine the answers to the above questions and to obtain all possible help in solving our own problems, sets of questionnaires were sent to 436 doctors in 47 states, Alaska, Hawaii, Panama, Puerto Rico, and Washington, D. C.

Two hundred thirty of these doctors were selected because I knew them personally, others because they belonged to various organizations or were recognized as preeminent in their respective specialties. The remainder of the recipients consisted of presidents of state and territorial societies, executive officers of these societies, and editors of state and regional journals. These doctors form a representative group of members of our local, state, and national medical organizations and include all the various specialties.

The sets of questionnaires included one of each of the following: private clinics owned by doctors, private clinics not owned by doctors, the status of radiologists in hospitals, the status of pathologists in hospitals, the status of anesthesiologists in hospitals, and one on medical schools and the practice of medicine by full-time salaried teachers in hospitals owned by the medical schools. Included in this last questionnaire were two questions on insurance problems in charity hospitals.

One can't give a true picture of the above matters by just answering questions with a "Yes" or a "No." Therefore, in the letter accompanying the questionnaire the recipients were requested to give their personal opinions concerning these matters, to send any other available information they might have pertinent to the situation existing in their states or communities, and to make suggestions about settling these controversial matters.

Three hundred twenty replies have been received, and all but a few of those answering have made a conscientious effort to help. Some have written detailed analyses of what is happening in their states and in their communities, and their opinions about the same. Others have obtained help in answering the questionnaire from various local and state committees or officers. Some have sent individual questionnaires on the different subjects to friends of theirs in specialties, to deans of medical schools, or to someone especially interested in the particular matter in question.

In these 320 replies, then, are opinions and facts, not only from those who answered, but from 126 other doctors. Others have sent clippings, reprints, bulletins, and journals containing special information on these subjects. In addition to the above, we have from the A.M.A. answers to questionnaires sent to all the medical schools in the United States and to the county and state societies where these schools are located.

To conserve space and avoid repetition, beginning in the next issue of our *Journal*, I shall give consolidated reports on the information received from these various sources.

Hal M. W. *W*anison.

President

Official Proceedings

106th Annual Session of the MEDICAL ASSOCIATION of GEORGIA

Atlanta, May 13-16, 1956

First Session, House of Delegates

Sunday, May 13, 1956

THE FIRST SESSION of the House of Delegates of the Medical Association of Georgia was called to order by President H. Dawson Allen, Jr., Milledgeville, at 5:15 p.m., in the Academy of Medicine, Atlanta, Georgia, on May 13, 1956.

President Allen called on Credentials Committee Chairman Leo Smith, Waycross, who reported a quorum present, and also later reported the following attendance:

Attendance

ALTAMAHA: J. B. Brown; BARTOW: William B. Quillian, Jr.; BEN HILL-IRWIN: H. L. Dismuke; BIBB: E. C. McMillan, J. B. Kay, Samuel Patton, W. W. Baxley, M. B. Hatcher; CARROLL-DOUGLAS-HARALSON: R. L. Denney; CHATTAHOOCHEE: D. C. Kelley; CHATTOOGA: W. P. Martin; CLAYTON-FAYETTE: F. A. Sams; COBB: W. C. Mitchell, M. M. Hagood; COFEE: Sage Harper; CRAWFORD W. LONG: James A. Green, Jr., R. H. Randolph; DECATUR-SEMINOLE: T. E. DuPree; DeKALB: W. A. Mendenhall, M. F. Simmons; DOUGHERTY: Glenn E. Seymour; EMANUEL: H. W. Smith; FLINT: O. K. Coleman; FLOYD: Stephen D. Smith, Ralph Johnson; FULTON: Herbert S. Alden, Thomas J. Anderson, Jr., Linton H. Bishop, Jr., Tully T. Blalock, Edgar Boling, W. W. Bryan, James H. Byram, Don F. Cathcart, Hugh Hailey, Alton V. Hallum, McClaren Johnson, J. Harry Lange, Ted F. Leigh, A. O. Linch, William A. Hopkins, Harold P. McDonald, Chris J. McLoughlin, Marvin A. Mitchell, Philip H. Nippert, Jack C. Norris, Purcell Roberts, Charles F. Stone, Lester Rumble, Jr., J. Frank Walker, J. J. Clark, Harriet E. Gillette,

Joseph D. McElroy, W. A. Selman; GEORGIA MEDICAL SOCIETY: John L. Elliott, Lee Howard, Jr., Ruskin King, T. A. Peterson; GLYNN: J. B. Mercer; GORDON, L. R. Lang; GRADY: C. K. Singleton; HABERSHAM: Jesse L. Walker; HALL: P. K. Dixon, Rafe Banks, Jr.; HART: L. B. Cacchioli; JACKSON-BARROW: A. A. Rogers, Jr.; JASPER: Marvin L. Greene; JEFFERSON: C. Roy Williams; McDUFFIE: A. G. LeRoy; MERIWETHER-HARRIS: W. P. Kirkland; MITCHELL: A. A. McNeill, Jr.; MUSCOGEE: Roy L. Gibson, George M. Hutto, Frank B. Schley, Robert H. Vaughan; NEWTON: C. B. Palmer; OCMULGEE: M. F. Arnold; PEACH BELT: H. E. Weems; POLK: Donald Schmidt; RANDOLPH TERRELL: J. C. Patterson; RICHMOND: Stephen W. Brown, Thomas W. Goodwin, C. M. Mulherin, R. C. Major, David R. Thomas, Jr., George W. Wright; SCREVEN: Gerald B. Hogsette; SOUTH GEORGIA: A. G. Little, Jr., F. G. Eldridge; SOUTHWEST GEORGIA: J. B. Martin; SPALDING: Virgil B. Williams; STEPHENS: P. B. Cleveland; SUMTER: J. H. Robinson; THOMAS-BROOKS: Oscar M. Mims, John B. Morton; TROUP: Charles T. Coward, H. Hilt Hammett, Jr.; UPSON: T. A. Sappington; WALKER-CATOOSA-DADE: Fred H. Simonton; WALTON: Charles S. Floyd; WARE: W. L. Pomeroy; WARREN: H. B. Cason; WAYNE: J. W. Yeomans; WHITFIELD: Paul L. Bradley; WORTH, W. P. Stoner.

County Medical Societies not represented at this House of Delegates session were as follows:

BALDWIN, BLUE RIDGE, BURKE, COLQUITT, COWETA, FRANKLIN, GRADY, JENKINS, LAMAR, LAURENS, RABUN, TATTNALL, TAYLOR, TELFAIR, TIFT, WASHINGTON, WILKES.

Other members of the House of Delegates in attendance were:

Hal M. Davison, Eustace A. Allen, J. W. Chambers, H. L. Cheves, W. G. Elliott, W. B. Schaefer, Neal F. Yeomans, Lee Howard, William Harbin, W. F. Reavis, C. F. Holton, C. L. Ayers, Enoch Callaway, A. M. Phillips, A. H. Bunce, W. A. Selman, and the Messrs. Krueger and Kiser of the headquarters office staff.

In compilation of attendance taken from the official roll, 54 county medical societies were represented by their duly elected delegates. Seventeen county medical societies were not represented at this session. Of a total of 133 delegates from their respective county medical societies, the official roll showed 104 delegates present at this session.

Reference Committees

President Allen then appointed the following House of Delegates Reference Committees:

REFERENCE COMMITTEE NO. 1: J. L. Walker, Clarkesville, chairman; John Mooney, Statesboro, vice-chairman; E. C. McMillan, Macon, secretary; J. M. Byne, Waynesboro; W. P. Martin, Summerville; Alex G. Little, Jr., Valdosta; Virgil B. Williams, Griffin; W. W. Bryan, Atlanta; Frank B. Schley, Columbus; and C. F. Holton, Savannah.

REFERENCE COMMITTEE NO. 2: Ruskin King, Savannah, chairman; M. F. Simmons, Decatur, vice-chairman; W. P. Stoner, Sylvester, secretary; A. G. LeRoy, Thomson; J. W. Palmer, Ailey; W. L. Pomeroy, Waycross; R. L. Denney, Carrollton; R. C. Major, Augusta; Roy L. Gibson, Columbus; and Grady N. Coker, Canton.

REFERENCE COMMITTEE NO. 3: Robert H. Vaughan, Columbus, chairman; Rafe Banks, Jr., Gainesville, vice-chairman; Linton H. Bishop, Jr., Atlanta, secretary; H. B. Cason, Warrenton; O. K. Coleman, Cordele; W. C. Mitchell, Smyrna; T. J. Floyd, Griffin; D. N. Thompson, Elberton; Samuel E. Patton, Macon; and Ralph Chaney, Augusta.

REFERENCE COMMITTEE NO. 4: McClaren Johnson, Atlanta, chairman; William B. Quillian, Cartersville, vice-chairman; George W. Wright, Augusta, secretary; J. W. Yeomans, Jesup; Oscar M. Mims, Thomasville; Don Schmidt, Cedartown; Charles T. Cowart, LaGrange; Milford B. Hatcher, Macon; and C. L. Ayers, Toccoa.

REFERENCE COMMITTEE NO. 5: M. F. Arnold, Hawkinsville, chairman; Lee Howard, Jr., Savannah, vice-chairman; Ralph N. Johnson, Rome, secretary; H. E. Weems, Perry; A. A. McNeill, Camilla; F. G. Eldridge, Valdosta; J. H. Nicholson, Valdosta; C. M. Mulherin, Augusta; James R. Green, Athens; and J. C. Patterson, Cuthbert.

REFERENCE COMMITTEE NO. 6 (Special): B. L. Shackelford, Atlanta, chairman; Glenn E. Seymour, Albany, vice-chairman; Fred H. Simonton, Chickamauga, secretary; R. C. McGahee, Augusta; Roy Williams, Wadley; J. B. Mercer, Brunswick; and J. W. Chambers, LaGrange, *ex-officio* member.

For the information of the House of Delegates, President Allen reported that Reference Committee No. 6 was appointed as instructed by the 1955 House of Delegates and would confine its deliberations to the proposed revisions of the Association's Constitution and By-Laws. No other items of business were referred to this committee.

Credentials Committee

President Allen then announced prior appointment of the following members to the Credentials Committee:

Leo Smith, Waycross, chairman; C. P. Savage, Montezuma, vice-chairman; and Herbert S. Alden, Atlanta.

Tellers Committee

President Allen then appointed the following members to the Tellers Committee:

Enoch Callaway, LaGrange, chairman; William Harbin, Rome, vice-chairman; C. F. Holton, Savannah; and W. A. Selman, Atlanta.

Speaker of the House

President Allen then announced that the Chair would entertain nominations for the offices of speaker and vice-speaker of the House of Delegates. On motion (J. W. Chambers, LaGrange—Eustace A. Allen, Atlanta) Thomas W. Goodwin, Augusta, was nominated for Speaker of the House of Delegates. It then was moved and seconded that nominations be closed, and by unanimous vote Dr. Goodwin was elected Speaker of the House of Delegates.

On motion (Harry L. Cheves, Union Point—David Henry Poer, Atlanta) Fred H. Simonton, Chickamauga, was nominated as Vice-Speaker of the House of Delegates. It was then moved and seconded that nominations be closed, the motion was passed unanimously, and Dr. Simonton was elected Vice-Speaker of the House of Delegates.

Speakers Remarks

Speaker Goodwin addressed the members of the House concerning the ground rules for the conduct of business before the House. Speaker Goodwin remarked:

"It seems that each succeeding session brings increasing problems both social and economic as well as medical. Our duty is not only with the changing problems associated with the practice of medicine. We have a great responsibility to see that our actions markedly contribute to the betterment of public health and its allied areas. Our best efforts must continually be directed, as always, to what is best for the people of Georgia. And to that end, we owe a great debt to our elected leaders in our Association and the committee chairmen who serve so many so well. May the action of the session of this body of duly elected representatives of each and every Association member reflect creditably upon our proud profession and significantly improve the art and science of medicine and the betterment of the people in Georgia."

In Memoriam

After a short prayer, Speaker Goodwin announced:

"I wish at this time to pay tribute to our forebears who have devoted their lives and skill in the service of our profession. Since the last session of this House, there were many former members of the Medical Association of Georgia who have been called from their labors by the Great Physician. May I suggest we well appreciate and pay tribute to their service and memory. I would ask that you remain standing while I read the names of our departed colleagues:

WILEY A. ADERHOLD, Carrollton, September 11, 1955
W. PRUITT ALLEN, Woodbury, February 29, 1956
WILLIAM B. ARMSTRONG, Atlanta, December 2, 1955
RUFUS A. ASKEW, Atlanta, July 5, 1955
JOSEPH SIDNEY BEARD, Edison, June 2, 1955

CHARLES DANIEL BOWDOIN, Atlanta, September 23, 1955
 JULIUS C. BURCH, Atlanta, October 23, 1955
 EMMETT ETHERIDGE BUTLER, Gainesville, May 5, 1925
 EDWIN S. BYRD, Atlanta, July 7, 1955
 W. L. CHAMPION, Atlanta, July 2, 1955
 WALLACE H. CLARK, LaGrange, August 30, 1955
 WILLIAM PETER COFFEE, Fitzgerald, February 7, 1956
 ALFRED TENNYSON COLEMAN, Dublin, September 2, 1955
 JOHN ALEXANDER CORRY, Barnesville, July 4, 1955
 WILLIAM FLETCHER FRIDDELL, Boston, October 9, 1955
 J. L. GARDNER, Sulphur Springs, August 28, 1955
 JOHN ELMO GARNER, Thomaston, January 24, 1956
 ROBERT B. GILBERT, SR., Greenville, August 16, 1955
 JOHN WILSON GOOD, Cedartown, December 19, 1955
 AUBREY HARPER, Wray, February 20, 1956
 HENRY TERRELL HARRISS, Washington, October 19, 1955
 CLAIR ABIE HENDERSON, Savannah, May 15, 1955
 HOWELL PARKS HOLBROOK, JR., Tucker, January 14, 1956
 EDGAR CASHION HOLMES, Moultrie, April 13, 1955
 HOLLIS F. HOPE, SR., Atlanta, November 2, 1955
 MATTHEW K. JENKINS, Atlanta, February 6, 1956
 RANDALL P. KENDALL, JR., Columbus, May 7, 1955
 JACKSON WILEY LANDHAM, Atlanta, July 1, 1955
 CHARLES COLDING LAWRENCE, Savannah, February 27, 1956
 HENRY GRADY LEE, Millen, December 26, 1955
 HENRY LAZARUS LEVINGTON, Savannah, February 28, 1956
 WILLIAM CULLEN MCCARVER, Vidette, July 24, 1955
 JOHN WALTON MCELROY, Ocilla, August 6, 1955
 J. M. MCKENZIE, Thomaston, January 2, 1956
 OTTO WALTER (Tom) MEISSNER, Athens, September 29, 1955
 LINUS J. MILLER, Atlanta, April 8, 1955
 FRANK BAXTER MITCHELL, SR., Crescent, July 3, 1955
 MALCOLM E. NOEL, Atlanta, February 15, 1956
 JOHN WESLEY ODEN, St. Petersburg, Fla., February 20, 1956
 JOHN JUDSON PILCHER, Wrens, January 14, 1956
 CHRIS H. PINSON, Atlanta, April 9, 1956
 ALBERT W. REHBERG, Cairo, September 16, 1955
 O. L. ROGERS, Sandersville, January 10, 1956
 ATTICUS SAMUEL SANDERS, Lake Burton, February 14, 1956
 E. S. SANDERSON, Augusta, July 16, 1954
 ROBERT E. STEGALL, Moultrie, January 14, 1956
 RALPH L. TAYLOR, Davisboro, January 22, 1956
 THOMAS L. TIDMORE, Atlanta, February 5, 1956
 WILLIAM H. TRIBBLE, Atlanta, July 26, 1955
 JAMES REUBEN WALLIS, Lovejoy, September 18, 1955
 FORD WARE, Macon, October 5, 1955
 GEORGE MARTIN WHITE, Rockmart, April 11, 1956
 CHARLES EDWARD WILLS, Washington, March 4, 1956
 BURR THADDEUS WISE, Plains, April 6, 1956

Approval of 1955 Minutes

Speaker Goodwin then called for the reading and adoption of minutes. The minutes of the House of Delegates, 105th Session, May 1st and May 3rd, 1955, Bon Air Hotel, Augusta, Georgia, was approved on motion (J. W. Chambers, LaGrange—Eustace A. Allen, Atlanta) as published in the June, 1955 issue of the *Journal of the Medical Association of Georgia* with no additions, deletions, or corrections.

Speaker Goodwin stated the next item of business to be the reports before the House of Delegates.

(A cross reference of the reports of officers, committee chairmen, addendum or minority reports and resolutions introduced at this session are listed below with the reference committee to which the report was referred. The full report and action by the reference committee and the House of Delegates are listed under the proceedings of the Second Session of the House of Delegates. See pages 227-295.)

Reports of Officers

President—H. Dawson Allen, Jr., Milledgeville—Reference Committee No. 1—See page 227.
 President-Elect—Hal M. Davison, Atlanta—Reference Committee No. 2—See page 234.
 Immediate Past President—William P. Harbin, Jr., Rome—No report.
 First Vice President—R. C. McGahee, Augusta; Addendum (Vice President's Duties)—David Henry Poer, Atlanta—Reference Committee No. 1—See page 229.
 Second Vice President—Stephen W. Brown, Augusta—Reference Committee No. 1—See page 229.

Secretary—David Henry Poer, Atlanta; Addendum (District Society Meetings)—David Henry Poer—Reference Committee No. 3—See page 246.
 Treasurer—David Henry Poer, Atlanta—Reference Committee No. 5—See page 272.
 AMA Delegates—C. H. Richardson, Sr., Macon; Eustace A. Allen, Atlanta; and Spencer A. Kirkland, Atlanta; Addendum (Osteopathy)—David Henry Poer, Atlanta—Reference Committee No. 4—See page 256.
 First District Councilor—Lee Howard, Sr., Savannah; Addendum (Liberty-Long-McIntosh)—David Henry Poer, Atlanta—Reference Committee No. 4—See page 259.
 First District Vice Councilor—Charles T. Brown, Guyton—Reference Committee No. 4—See page 259.
 Second District Councilor—George R. Dillinger, Thomasville—Reference Committee No. 5—See page 271.
 Second District Vice Councilor—J. Z. McDaniel, Albany—No report.
 Third District Councilor—W. G. Elliott, Cuthbert—Reference Committee No. 1—See page 229.
 Third District Vice Councilor—Luther H. Wolff, Columbus—Reference Committee No. 1—See page 230.
 Fourth District Councilor—J. W. Chambers, LaGrange—Reference Committee No. 2—See page 234.
 Fourth District Vice Councilor—Clarence B. Palmer, Covington—Reference Committee No. 2—See page 235.
 Fifth District Councilor—Mark S. Dougherty, Jr., Atlanta—Reference Committee No. 3—See page 249.
 Fifth District Vice Councilor—J. G. McDaniel, Atlanta—No Report.
 Sixth District Councilor—Henry H. Tift, Macon—Reference Committee No. 4—See page 260.
 Sixth District Vice Councilor—H. G. Weaver, Macon—No report.
 Seventh District Councilor—D. Lloyd Wood, Dalton—Reference Committee No. 5—See page 271.
 Seventh District Vice Councilor—Ralph W. Fowler, Marietta—No report.
 Eighth District Councilor—Neal F. Yeomans, Waycross—Reference Committee No. 1—See page 271.
 Eighth District Vice Councilor—James M. Hicks, Brunswick—No report.
 Ninth District Councilor—W. Bruce Schaefer, Toccoa—Reference Committee No. 2—See page 235.
 Ninth District Vice Councilor—Charles R. Andrews, Jr., Canton—No report.
 Tenth District Councilor—H. L. Cheves, Union Point—Reference Committee No. 3—See page 249.
 Tenth District Vice Councilor—J. Victor Roule, Augusta—No report.
 Council of the Medical Association of Georgia—J. W. Chambers, LaGrange, Chairman; Addendum (Special Report on Talmadge Hospital Policy)—J. W. Chambers—Reference Committee No. 2—See page 235.
 Council Audit and Appropriations Committee—W. Bruce Schaefer, Toccoa, Chairman—Reference Committee No. 5—See page 274.

Reports of Committees

Scientific Work—Fred H. Simonton, Chickamauga, Chairman—Reference Committee No. 1—See page 230.
 Legislation—Grady N. Coker, Canton, Chairman—Reference Committee No. 1—See page 230.
 Medical Education—Edgar R. Pund, Augusta, Chairman—Reference Committee No. 2—See page 243.
 Medical Defense—David Henry Poer, Atlanta, Chairman—Reference Committee No. 3—See page 250.
 Professional Conduct—A. M. Phillips, Macon, Chairman—Reference Committee No. 4—See page 260.
 History & Vital Statistics—J. Calvin Weaver, Atlanta, Chairman—Reference Committee No. 5—See page 275.

Public Health—T. A. Sappington, Thomaston, Chairman; Addendum (Salk Polio Vaccine)—David Henry Poer, Atlanta—Reference Committee No. 1—See page 231.

Maternal and Infant Welfare—Peter Hydrick, College Park, Chairman; Addendum (Nurses Obstetrics Training)—David Henry Poer, Atlanta; Addendum (Advisory Members)—Peter Hydrick—Reference Committee No. 5—See page 275.

Woman's Auxiliary Advisory—Shelley C. Davis, Atlanta, Chairman—Reference Committee No. 3—See page 250.

Constitution and By-Laws—J. W. Chambers, LaGrange, Chairman—Reference Committee No. 6—See page 280.

Awards—Ted F. Leigh, Atlanta, Chairman—Reference Committee No. 4—See page 260.

Industrial Health—Duncan Shepard, Atlanta, Chairman—Reference Committee No. 5—See page 276.

Public Relations—Chris J. McLoughlin, Atlanta, Chairman—Reference Committee No. 1—See page 231.

Cancer—J. Elliot Scarborough, Atlanta, Chairman—Reference Committee No. 2—See page 243.

Rural Health—George T. Nicholson, Cornelia, Chairman—No report.

Insurance Board—David R. Thomas, Jr., Augusta, Chairman—Reference Committee No. 4—See page 262.

Veterans' Affairs—Hartwell Joiner, Gainesville, Chairman—Reference Committee No. 5—See page 277.

Hospitals—Milford B. Hatcher, Macon, Chairman—Reference Committee No. 1—See page 232.

Medical Civil Preparedness—Edgar M. Dunstan, Atlanta, Chairman—Reference Committee No. 2—See page 244.

American Medical Education Foundation—John L. Chandler, Jr., Augusta—No report.

Blood Banks—Warren B. Matthews, Atlanta, Chairman; Addendum (Minimal Blood Bank Standards)—Warren B. Matthews—Reference Committee No. 4—See page 263.

Calhoun Lectureship—Glenville Giddings, Atlanta, Chairman—Reference Committee No. 5—See page 277.

Chronic Illness—L. Minor Blackford, Atlanta, Chairman—No report.

Crawford W. Long Memorial—Lester Rumble, Jr., Atlanta, Chairman—Reference Committee No. 3—See page 250.

Mental Health—Rives Chalmers, Atlanta, Chairman—Reference Committee No. 3—See page 251.

Liaison Advisory Board to the Georgia Society for Crippled Children—J. C. Hughston, Columbus, Chairman—Reference Committee No. 4—See page 268.

State Advisory Committee to the Selective Service System—William G. Hamm, Atlanta, Chairman—Reference Committee No. 1—See page 232.

Report of the Headquarters Office—Mr. Milton D. Krueger, Executive Secretary, and Mr. John F. Kiser, Asst. Executive Secretary, Atlanta—Reference Committee No. 3—See page 252.

Report of the *Journal of the Medical Association of Georgia*—Edgar Woody, Jr., Atlanta, Editor, and Miss Frances H. Porcher, Atlanta, Managing Editor—Reference Committee No. 3—See page 254.

Woman's Auxiliary to the Medical Association of Georgia—Mrs. Robert C. Major, Augusta, President; Addendum—Mrs. Robert C. Major—Reference Committee No. 5—See page 277.

Better Health Council—Mrs. W. Bruce Schaefer, Toccoa, President; Addendum—Mrs. W. Bruce Schaefer—Reference Committee No. 4—See page 260.

General Practitioner of the Year

Speaker Goodwin then stated the next order of business was nominations for "General Practitioner of the Year." Speaker Goodwin appointed a Tellers Committee of Delegates Roy L. Gibson, Columbus; Ralph Chaney, Augusta; and Harold McDonald, Atlanta,

and instructed the delegates that after nominations were received, they would vote by secret ballot. Speaker Goodwin called on Chairman of Council Chambers to submit any nominations received by the Council, and Chairman Chambers placed in nomination the names of three general practitioners as received by Council from the county medical societies. A secret ballot was taken and the Tellers Committee announced the following result: Sterling Jernigan, Sr., Sparta, named "General Practitioner of the Year."

The Chair called for other unfinished business, and there being none, Speaker Goodwin then called for New Business and stated that it was now in order for the Chair to receive resolutions.

Resolutions

- Res. No. 1—Hospital Chaplains—Philip H. Nippert, Atlanta—Reference Committee No. 5—See page 279.
- Res. No. 2—World Medical Association—Chris J. McLoughlin—Reference Committee No. 3—See page 255.
- Res. No. 3—AMA Regional Meetings—Don F. Cathcart, Atlanta—Reference Committee No. 5—See page 279.
- Res. No. 4—Sears Roebuck Foundation—J. L. Walker, Clarksville—Reference Committee No. 1—See page 233.
- Res. No. 5—AMA Dues—David Henry Poer, Atlanta—Reference Committee No. 3—See page 255.
- Res. No. 6—Corporate Practice of Medicine by Hospitals—C. J. Roper, Jasper—Reference Committee No. 2—See page 244.
- Res. No. 7—Standardization of Insurance Forms—Robert H. Vaughan, Columbus—Reference Committee No. 4—See page 263.
- Res. No. 8—Workmen's Compensation—Paul L. Bradley, Dalton—Reference Committee No. 5—See page 279.
- Res. No. 9—Marriage Law—Donald Schmidt, Cedartown—Reference Committee No. 3—See page 256.
- Res. No. 10—Corporate Practice of Medicine—Lester Rumble, Jr., Atlanta—Reference Committee No. 2—See page 244.
- Res. No. 11—Automobile Safety—Eustace A. Allen, Atlanta—Reference Committee No. 5—See page 280.
- Res. No. 12—Board of Health Appointments—Withdrawn by Fred Simonton, Chickamauga (No action as was withdrawn).
- Res. No. 13—Sterilization—Richmond County Delegation—Reference Committee No. 3—See page 256.
- Res. No. 14—Talmadge Hospital Policy—MAG Council—Reference Committee No. 2—See page 245.
- Res. No. 15—Honorary Membership—MAG Council—Reference Committee No. 4—See page 296.
- Res. No. 16—1957 Savannah MAG Meeting—Ruskin King, Savannah—Reference Committee No. 4—See page 270.
- Res. No. 17—1957 Shipboard Cruise Meeting Savannah—Ruskin King, Savannah—Reference Committee No. 4—See page 270.
- Res. No. 18—Standardized Insurance Forms—Georgia Medical Society—Reference Committee No. 3—See page 256.

The Chair then called for any other items of new business and there being none, Speaker Goodwin announced that it was his pleasure to ask Joseph S. Skobba, Atlanta, to introduce the distinguished guest and speaker, Major General S. B. Hays, Surgeon General, Department of the Army, Washington, D. C. After Dr. Skobba's introduction, Major General Hays spoke on "Military Problems and the Civilian Physician." Following General Hays' address, the meeting was adjourned at 6:50 p.m.

General Business Session

Monday, May 14, 1956

THE GENERAL BUSINESS SESSION of the Medical Association of Georgia was called to order by President H. Dawson Allen, Jr., Milledgeville, at 11:45 a.m. in the Exhibit Hall Meeting Room, Atlanta Biltmore Hotel, Atlanta, Georgia.

The invocation was given by the Reverend Edgar A. Padgett, Pastor of the Sardis Methodist Church, Atlanta.

Following the invocation, McClaren Johnson, Atlanta, President of the Fulton County Medical Society, delivered a brief address of welcome in behalf of the host society, Fulton County Medical Society.

President Allen called on the Honorable William B. Hartsfield, Mayor of Atlanta, who welcomed the membership in behalf of the city of Atlanta.

President Allen then introduced Dwight H. Murray, Napa, California, President-Elect of the American Medical Association, who spoke on "Your AMA—Some Things to Expect in 1956."

President Allen announced that J. W. Chambers, LaGrange, had been appointed acting secretary of the Association for the day because of the emergency absence of Secretary Poer. Dr. Allen then relinquished the gavel to Vice President R. C. McGahee.

President H. Dawson Allen, Jr., Milledgeville, delivered his President's Address, and following this, Vice President R. C. McGahee was relieved as Presiding Officer by President Allen.

President Allen called upon Enoch Callaway, LaGrange, Chairman of the Tellers Committee, who made an announcement concerning the rules of voting and the area of the ballot box.

The Chair called for nominations from the floor for the following offices: president-elect; 1st vice president; 2nd vice president; delegate to the AMA (term beginning January 1, 1957); alternate delegate to the AMA (term beginning January 1, 1957); delegate to the AMA (term beginning January 1, 1957); alternate delegate to the AMA (term beginning January 1, 1957); Fifth District councilor (term expires 1959); Fifth District vice councilor (term expires 1959); Sixth District councilor (term expires 1959); Sixth District vice councilor (term expires 1959); Seventh District councilor (term expires 1959); Seventh District vice councilor (term expires 1959); Eighth District councilor (term expires 1959); Eighth District vice councilor (term expires 1959).

Nominations for these offices were as follows, and

because only one nomination was received from the floor by the Chair for each of these offices, the Chair instructed the acting secretary to cast a unanimous ballot in behalf of the membership for the election of the men nominated.

PRESIDENT-ELECT—W. Bruce Schaefer, Toccoa, nominated by C. L. Ayers, Toccoa; seconded by Charles R. Andrews, Jr., Canton; William Harbin, Rome, and C. F. Holton, Savannah.

FIRST VICE PRESIDENT—Carl C. Aven, Atlanta, nominated by Mark S. Dougherty, Jr., Atlanta seconded by B. L. Shackleford, Atlanta, and William R. Dancy, Savannah.

SECOND VICE PRESIDENT—Bernard P. Wolff, Atlanta, nominated by J. C. Patterson, Cuthbert; seconded by Eustace A. Allen, Atlanta.

AMA DELEGATE—(Term beginning January 1, 1957)—Spencer A. Kirkland, Atlanta, nominated by Jack C. Norris, Atlanta; seconded by McClaren Johnson, Atlanta.

AMA ALTERNATE DELEGATE—(Term beginning January 1, 1957)—Henry H. Tift, Macon, nominated by A. B. Conger, Columbus; seconded by W. G. Elliott, Cuthbert.

AMA DELEGATE—(Term beginning January 1, 1957)—Eustace A. Allen, Atlanta, nominated by B. L. Shackleford, Atlanta; seconded by Don F. Cathcart, Atlanta.

AMA ALTERNATE DELEGATE (Term beginning January 1, 1957)—William R. Dancy, Savannah, nominated by W. A. Selman, Atlanta, seconded by C. L. Ayers, Toccoa.

FIFTH DISTRICT COUNCILOR—J. G. McDaniel, Atlanta.

FIFTH DISTRICT VICE COUNCILOR—Charles S. Jones, Atlanta.

SIXTH DISTRICT COUNCILOR—Henry H. Tift, Macon.

SIXTH DISTRICT VICE COUNCILOR—George H. Alexander, Forsyth.

SEVENTH DISTRICT COUNCILOR—D. Lloyd Wood, Dalton.

SEVENTH DISTRICT VICE COUNCILOR—Ralph W. Fowler, Marietta.

EIGHTH DISTRICT COUNCILOR—F. G. Eldridge, Valdosta.

EIGHTH DISTRICT VICE COUNCILOR—James N. Hicks, Brunswick.

There being no opposition to the nominations for these offices, nomination was tantamount to election and the acting secretary cast a unanimous ballot in behalf of the membership for each of these nominees, and the Chairman of the Committee on Tellers, Enoch Callaway, then rose to say that in view of the unanimous election there would be no balloting during the 106th Annual Session.

There being no further business at this General Session it was moved and duly seconded that the meeting be adjourned.

Second Session, House of Delegates

(Recessed)

Tuesday, May 15, 1956

THE SECOND SESSION (recessed) of the House of Delegates of the Medical Association of Georgia was called to order by Speaker Goodwin at 2:20 p.m. at the Academy of Medicine, Atlanta, Georgia, May 15, 1956.

Speaker Goodwin then called on Credentials Committee Chairman Leo Smith, Waycross, who reported a quorum present, and also later reported the following attendance.

Attendance

BARTOW: William B. Quillian, Jr.; BIBB: E. C. McMillan; J. B. Kay; Samuel E. Patton; Milford B. Hatcher; BULLOCH-CANDLER-EVANS: John Mooney; CHATTAHOOCHEE: D. C. Kelley; CHATTOOGA: W. P. Martin; CHEROKEE-PICKENS: Ben K. Looper; CLAYON-FAYETTE: F. A. Sams, Jr.; COBB: W. C. Mitchell, M. M. Hagood; COFFEE: Sage Harper; CRAWFORD W. LONG: James A. Green, Jr., R. H. Randolph; DeKALB: W. A. Mendenhall; DOUGHERTY: Glenn E. Seymour; ELBERT: D. N. Thompson; FLINT: O. K. Coleman; FLOYD: Stephen D. Smith, Ralph N. Johnson; FULTON: Herbert S. Alden, Thomas J. Anderson, Jr., Edgar Boling, William W. Bryan, Don F. Cathcart, Hugh Hailey Alton V. Hallum, McClaren Johnson, Ted F. Leigh, A. O. Linch, William A. Hopkins, Marvin A. Mitchell, Philip H. Nippert, Purcell Roberts, B. L. Shackelford, Charles F. Stone, Lester Rumble, Jr., C. W. Strickler, Jr., J. Frank Walker, Harriet E. Gillette, Joseph D. McElroy; GEORGIA MEDICAL SOCIETY: John L. Elliott, Ruskin King, T. A. Peterson; GLYNN: Joseph B. Mercer; GORDON: Lewis R. Lang; HABERSHAM: J. L. Walker; HALL: P. K. Dixon, Rafe Banks, Jr.; JASPER: Marvin L. Greene; JEFFERSON: C. Roy Williams; McDUFFIE: A. G. LeRoy; MUSCOGEE: Roy L. Gibson, Frank Schley, Robert H. Vaughan; NEWTON: Clarence B. Palmer; OCMULGEE: M. F. Arnold; OCONEE VALLEY: J. H. Nicholson; POLK: Donald Schmidt; RICHMOND: Stephen W. Brown, Thomas W. Goodwin, R. C. McGahee, Charles McL. Mulherin, R. C. Major, David R. Thomas, Jr., George W. Wright; SOUTH GEORGIA: A. G. Little, Jr., F. G. Eldridge; SOUTHEAST GEORGIA: J. W. Palmer; SOUTHWEST GEORGIA: J. B. Martin; SPALDING: Virgil B. Williams, T. J. Floyd, Jr.; SUMTER: J. H. Robinson, III; THOMAS-BROOKS: Oscar M. Mims; TROUP: Charles T. Cowart, H. Hilt Hammitt, Jr.; UPSON: T. A. Sappington; WALKER-CATOOSA-DADE: Fred H. Simonton; WALTON: Charles S. Floyd; WARE: W. L. Pomeroy, Leo Smith; WARREN: H. B. Cason; WAYNE: J. W. Yeomans; WHITFIELD: Paul L. Bradley; WORTH: W. P. Stoner.

County medical societies not represented at this Second Session of the House of Delegates are as follows:

ALTAMAHA, BALDWIN, BEN HILL-IRWIN, BLUE RIDGE, BURKE, CARROLL-DOUGLAS-HARALSON, COLQUITT, COWETA, DECATUR-SEMINOLE, EMAN-

UEL, FRANKLIN, GRADY, HART, JACKSON-BARROW, JENKINS, LAMAR, LAURENS, MERIWETHER-HARRIS, MITCHELL, PEACH BELT, RABUN, RANDOLPH-TERRELL, SCREVEN, STEPHENS, TATTNALL, TAYLOR, TELFAIR, TIFT, WASHINGTON, WILKES.

Other members of the House of Delegates in attendance were:

William R. Dancy, C. L. Ayers, H. Dawson Allen, Jr., William P. Harbin, Jr., W. F. Reavis, Hal M. Davison, Grady N. Coker, George R. Dillinger, W. Bruce Schaefer, Harry L. Cheves, Sr., Neal F. Yeomans, W. G. Elliott, Eutace A. Allen, J. W. Chambers, D. Lloyd Wood, Henry H. Tift, Mark S. Dougherty, Jr., and Enoch Callaway.

In a compilation of attendance taken from the official roll, 45 county medical societies were represented by their duly elected delegates. Thirty county medical societies had no representatives at the Second Session. Of a total of 133 delegates from the respective county medical societies, the official roll showed 87 delegates present at this session.

REPORT OF REFERENCE COMMITTEE NO. 1

J. L. Walker, Chairman

(The following reports as presented to this reference committee are printed in full with the reference committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 1 met in the MAG Council Room at 8:30 a.m., May 14, 1956. Present were J. L. Walker, Clarkesville, chairman; E. C. McMillan, Jr., Macon, secretary; W. W. Bryan, Atlanta; W. P. Martin, Summerville; Alex G. Little, Valdosta; Virgil B. Williams, Griffin; Frank Schley, Columbus; and C. F. Holton, Savannah.

President

H. D. ALLEN, JR.

It is very gratifying to look on the past year and realize that the Medical Association of Georgia has made much progress. There has been a steady growth of membership and equally pleasing has been the increase in membership in the AMA.

With very few exceptions all committees are functioning most efficiently. The reports of each committee set forth the activities of the year with much comprehensiveness and detail, and I can only add that each committee has the gratitude of all for this unselfish service.

The headquarters office staff, under the capable direction of our Secretary-Treasurer, now serving his

second term, along with the capable assistance of the Executive Secretary, the Assistant Executive Secretary and the entire office staff, have matured and settled down to a most experienced and effective unit.

With the assistance of the Fulton County Medical Society as owner of headquarters office space, this area has been remodeled with a meeting room for the Council and other official groups and better office partitioning which has added much to the convenience and comfort of the office force as well as the individuals and groups conducting business with the Association.

The flooding of the office by heavy rains of last June caused much damage to the office equipment as well as offices. The Fulton County Medical Society again came to the rescue by renovating damaged floors and walls. The Association's greatest loss was the obsolete addressograph. This was replaced by a much more modern and efficiently operating machine which, I am sure, makes this loss negligible.

The biographical file, an innovation in office records of this year, has reached only 50% of the old members. It is hoped that this will be completed this year.

The Journal published from headquarters continues to maintain its highest standards both literary and artistic. There is no criticism of the content as selected by the editorial staff. I am concerned though with the placement of some of the insert advertisements and as to whether or not full and prompt editorial consideration is being given to all papers presented to the scientific sessions and manuscripts left with the Editorial Board. It is regretted, however, that I have not been able to attend the meetings of the Publication Committee.

The Council has continued the policy of having three meetings away from headquarters as guests of officers and Councilors. At the first of these in September, I was co-host with the Tenth District Councilor, Harry Cheves, who has a lakeside retreat in my home county. We met as guests of the Second District Councilor, George Dillinger, in December, and the First District Councilor, Lee Howard, in March. This custom, I trust, will continue, as it seems to me to have a definite public relations value and also a very beneficial change of perspective. Here I commend the Council's report to every delegate, as this gives a complete picture of all the many details of headquarters operations.

Our Assistant Executive Secretary has spear-headed our field work. He has shown abounding energy and enthusiasm in carrying organization plans and legislative programs to the grass roots. He is making splendid progress in consolidating smaller counties into country group societies. A rough statistical evaluation impresses me that these consolidations have accounted for 50% of the 1955 membership increase. The full impact of his efforts will be best felt this year. His organizing the legislative program with meetings at a county group level with legislators and

local physicians earned him, as well as our state organization, much respect from these lawmakers. I firmly believe his case against the naturopaths put an end to strictly autonomous licensing boards in Georgia and will lead to stricter laws for all plying the healing arts. Without detracting credit from our field secretary's efforts, I am sure he joins me in acknowledging the ready response and help he received in both plans from the other office staff, local physicians and especially the Chairman of the Public Relations Committee who has joined him in several of his field trips with the public relations program.

Proper licensing boards with proper relations with the Department of State have definite economic value to those holding license. These boards, however, should be self-sustaining and we should welcome the yearly \$3.00 registration fee. The roster of licensed physicians, nurses and technicians is certainly worth this fee and probably costs this amount to compile and publish.

The Commission for the Study of Indigent Care in Hospitals was approved as a resolution of the senate but without appropriations for implementation. Perhaps with volunteers from the Medical Association of Georgia, the Georgia Hospital Association and the Department of Hospitals of the State Board of Health we can accomplish this without expense to the State and I recommend this as a constructive legislative program for this coming year.

My predecessor in office requested in his last year's report that we all pray for a happy solution to the conflict between the Medical College of Georgia and the Medical Association through the Council and two meetings of the House of Delegates. As we have been unable to make our adverse points of ethics and legality before those responsible for the operation of the college's teaching hospital, as well as the legislature, I feel that we should recognize that our sense of ethics is just too esoteric for the non-medical mind to understand and should drop this matter until some phase of operation produces overt exploitation in the sense of unwarranted financial gain at the expense of the patients. In my mind the great discovery set forth in the Flexner Report of 1910 was that only one medical school in the United States offered adequate medical education and the secret of this school was that the faculty and teaching hospital staff were unified and employed primarily as teachers. To me this situation finds no parallel in the Iowa case where the pathologist, radiologist and anesthetist were seeking only the same privileges of charging fees as was granted to the clinical staff of a hospital.

In my visits to many of the district society meetings, the 50th Anniversary Meetings of two county societies, one county group organization meeting and two county groups of secretaries and presidents for our public relations program, I have sensed an unusual seriousness of purpose on the part of members of all groups as they are here closest to their base of

operations. If the definite issues concerning ethics in hospital operation policies and legislative programs have contributed to this state of mind, we have all been benefitted.

Just as an issue for the coming year, I suggest that sickness and accident insurance companies add the economic functions of a factor to negotiate schedules of fees as full payment as contrasted with obligations being fully discharged only by arrangements with the purveyors of the services.

It is by custom that the report of our Auxiliary be given directly to the House of Delegates by its President. The ladies are complete complement in all matters of goodwill, good conduct and good public relations. Through their efforts of the past our greatest contribution to medical education in Georgia has been achieved. I have hints that they are pushing our American Medical Education Foundation Program and I wish to welcome this with the earliest congratulations. I expect to take this to them in person along with thanks for all their efforts and accomplishments of the past year. I will also ask them to urge compliance from their husbands as to our wishes for biographical data for our permanent files. This will save digging through rosters and old issues of *The Journal* and may be of value to their children.

Reference Committee Recommendation—The committee considered the President's Report and wishes to approve the report and commend Dr. Allen upon his report. His comment on the Eugene Talmadge Memorial Hospital problem was referred to another reference committee. His comments upon the selection of papers for publication and the placement of advertisements in the *Journal of the Medical Association of Georgia* were thoroughly discussed, and the committee felt that the present editor and managing editor are handling the matter adequately. The committee wishes to join with Dr. Allen in commending the excellent work of Mr. John Kiser, Assistant Executive Secretary.

House of Delegates Action—Recommended adoption of the President's Report as presented by the reference committee, which was moved, seconded, and adopted.

First Vice-President

R. C. MCGAHEE

The meetings of the Council have been attended with one exception. There have been no requests for any other duties of this office. Since it is largely honorary in nature, I wish to express my appreciation to the Association.

Reference Committee Recommendation—The report of the First Vice President, R. C. McGahee, Augusta, was approved by the reference committee.

House of Delegates Action—Recommended adoption of the First Vice President's Report as presented by the reference committee, which was moved, seconded and adopted.

Second Vice-President

STEPHEN W. BROWN

No report received.

Reference Committee Recommendation—The report of the Second Vice President, Stephen W. Brown, Augusta, was approved by the reference committee.

House of Delegates Action—Recommended adoption of the Second Vice President's Report as presented by the reference committee, which was moved, seconded and adopted.

ADDENDUM

MAG Vice Presidents' Duties

DAVID HENRY POER, *Secretary*

For the past several years the vice-presidents of the Medical Association of Georgia have requested that specific duties be assigned them in their capacities as Association officers. The definition of their duties and responsibilities poses a problem due to the brief term of office difficulties of over-the-state liaison between Association officers.

The Executive Committee of Council should reserve suggestions from members of the Association House of Delegates as to how these officers might be more effectively utilized in the interests of both representing the Association and functioning in behalf of the Association.

Reference Committee Recommendations—Reference Committee No. 1 suggests that the president utilize the services of the vice presidents to assist him in every way possible, particularly in attending district meetings.

House of Delegates Action—Recommended adoption of the MAG Vice Presidents' Duties Addendum Report as presented by the reference committee, which was moved, seconded and adopted.

Third District Councilor

W. G. ELLIOTT

The physician population of the Third District has remained about the same. There have been some changes in the medical societies.

Crisp, Dooley and Turner Counties have combined to form the Flint Society. This gives a good sized Society, and meetings are held at regular intervals and they have had some good programs.

The Peach Society has been formed from the Peach, Macon and Houston counties. They have five members and make a better Society than they had in the one County Society. Several doctors in these counties belong to the Bibb County Society and the Sumter County Society.

The Sumter Society is very active and meets monthly, except during the summer vacation months.

The Muscogee Society is very active and meets monthly except during vacation months and always has a good program. They continue to publish a very good monthly bulletin.

The other societies are more or less inactive and meet only occasionally, from two to four times yearly.

There were 186 Medical Association of Georgia members from the Third District, December 31, 1955, as compared to 187 members, December 31, 1954. There were 158 American Medical Association members, December 31, 1955, as compared to 146 members as of December 31, 1954.

A District meeting was held in Columbus in May, 1955, in conjunction with the Georgia Tuberculosis Association. Another District meeting was held in November, 1955, in Americus, and a very good program was given, and was fairly well attended. Meetings are usually held in April and November of each year.

THIRD DISTRICT MEMBERSHIP

Counties	Members December 31, 1955		Members December 31, 1954	
	MAG	AMA	MAG	AMA
Ben Hill-Irwin	11	9	10	8
Flint	21	19	17	6
Peach Belt	5	4	5	4
Muscogee	97	85	98	87
Ocmulgee	13	10	12	10
Randolph-Terrell	13	9	15	10
Sumter	19	18	20	17
Taylor	5	4	5	4
Wilcox	2	—	5	—
TOTAL	186	158	187	146

Reference Committee Recommendation—The Third District Report from W. G. Elliott, Cuthbert, was accepted.

House of Delegates Action—Recommended adoption of the Third District Councilor's report as presented by the reference committee, which was moved, seconded and adopted.

Third District Vice-Councilor

LUTHER H. WOLFF

Attended Council meetings in Atlanta and Thomasville. Nothing further to report.

Reference Committee Recommendation—The report of the Vice Councilor of the Third District, Luther H. Wolff of Columbus, was accepted.

House of Delegates Action—Recommended adoption of the Third District Vice Councilor's Report as presented by the reference committee, which was moved, seconded and adopted.

Scientific Work Committee

FRED H. SIMONTON, *Chairman*

The report of the Scientific Work Committee consists of the program of the 106th Annual Session, May 13-16, 1956, Atlanta Biltmore Hotel, Atlanta, Georgia.

Reference Committee Recommendation—The Scientific Work Committee Report consisted of the program of the 106th Annual Session, and no specific report other than this has been received. Under this heading, however, the reference committee recommends that speakers be informed well in advance that their papers may be published so that they may prepare them in a form suitable for publication prior to the MAG meeting.

House of Delegates Action—Recommended adoption of the Scientific Work Committee Report as presented by the reference committee, which was moved, seconded and adopted.

Legislation Committee

GRADY N. COKER, *Chairman*

State Legislation—The Committee sponsored this year: a bill to repeal the Naturopathy Act of 1950; a bill to amend the Talmadge Hospital Enabling Act; and a resolution establishing a Hospital Care Study Commission.

As many of you now know, the Naturopathy Law was repealed and the Hospital Care Study Commission was established. The amendment to the Talmadge Hospital Enabling Act died in a Subcommittee following a public hearing. (Further information concerning this amendment will be made by a special Committee appointed by Council.)

During the Session of the General Assembly, other items of legislation were brought to the attention of the Committee.

Optometry—Some controversy surrounded the passage of a bill redefining the practice of optometry. After careful study by Ophthalmologists and the Association's attorney, it was felt that this bill was not injurious to the general public and did not constitute an encroachment on the practice of medicine.

Milledgeville Hospital—A Study Commission to consider the possibility of transferring Milledgeville Hospital to the Health Department was established by a Senate Resolution.

Workmen's Compensation—Two bills were introduced in the General Assembly which would have changed the manner in which physicians are now selected under the Workmen's Compensation Act. The MAG took no position on these bills and both measures failed to pass.

Post Mortem Act—An attempt to iron out technical problems in the Georgia Post Mortem Act failed and the bill was left on the calendar due to objections raised by several members of the House.

Physicians will be permitted to make telephone prescriptions for certain non-addictive narcotic compounds and will be required to renew their licenses annually at a fee of \$3.00 in accordance with two bills that were passed by the General Assembly. Withdrawn was a bill sponsored by the Georgia Board of Medical Examiners requiring that all interns be licensed.

The Committee did not recommend changing the Medical Practice Act at this time. A Joint Committee of representatives from the Examining Board and the MAG is planning a general revision of the Act to be presented to the General Assembly in 1957.

National Legislation—On the national level, the Committee was largely concerned with the Social Security Amendments of 1955, H.R. 7225. The provision of this bill in regard to cash disability benefits was strongly opposed by the Association and the Chairman of Council, J. W. Chambers, testified against this provision before a public hearing of the U. S. Senate Finance Committee. Numerous telegrams and informational material concerning H. R. 7225 were handled through the headquarters office.

The bill extending the Doctor Draft Law was strongly opposed by the Association. The Association also opposed H.R. 483, providing for the commissioning of Osteopaths in the medical corps of the Armed Services. H.R. 483 is pending in the Senate Armed Services Committee as this report was written.

Since the Committee concentrated this year on State Legislation, the members were not as well informed in regard to national legislation. Steps should be taken next year to increase interest in national affairs among the members of the Association.

Reference Committee Recommendation—The report of the Legislation Committee, Grady N. Coker, Canton, Chairman, was accepted, and the reference committee wishes to commend Dr. Coker, the Legislation Committee, and Mr. John F. Kiser for their work in obtaining the repeal of the Naturopath Act of 1950.

House of Delegates Action—Recommended adoption of the Legislation Committee Report as presented by the reference committee, which was moved, seconded and adopted.

Public Health Committee

T. A. SAPPINGTON, *Chairman*

The Committee has worked with the Public Health Department in setting up a place of distribution of Polio Vaccine over the State. Although some parts of the program have been opposed by the Chairman of the Committee, it is felt that probably the best solution possible to the handling and distribution of the vaccine is being done.

The Joint Committee on Health and Education requested through Dr. Lester M. Petrie that a committee be appointed to determine a battery of suitable health screening tests which could be established as a periodic health appraisal for all personnel employed in the school system of Georgia. Your Committee is working on this at the present time and hopes to have definite recommendations presented to the Council of the MAG before the next annual session.

It is felt that the Health Department of the State of Georgia is doing an excellent job and that they are to be commended. It is also believed that there is a definite closeness between the Health Department and the MAG as it should unquestionably be.

Reference Committee Recommendation—The report of the Public Health Committee, T. A. Sappington, Thomaston, Chairman, was approved.

House of Delegates Action—Recommended adoption of the Public Health Committee Report as presented by the reference committee, which was moved, seconded and adopted.

ADDENDUM

Salk Polio Vaccine

DAVID HENRY POER, *Secretary*

It is recommended that the House of Delegates of the Medical Association of Georgia disapprove the "give-away" program of the United States Public Health Service providing Salk Polio Vaccine to everyone without cost. This is against the fundamental American principle of providing medical care for those able to pay for said care. This vaccine would, of course, be provided free to the medically indigent or to those for whom payment would constitute a hardship. These qualifications should be determined by each individual physician who also pledges to administer the vaccine without charge at all times when the patient is unable to pay for such service.

Reference Committee Recommendation—The addendum report to the Public Health Committee Report regarding Salk Polio Vaccine was not approved by the reference committee. The reference committee wishes to recommend that the Health Department of the State of Georgia distribute polio vaccine in the same way they handle small pox, D. P. T., and the typhoid vaccine.

House of Delegates Action—Recommended adoption of the reference committee recommendations concerning the Salk Polio Vaccine Addendum Report to the Public Health Committee Report, which was moved, seconded and adopted.

Public Relations Committee

CHRIS J. McLOUGHLIN, *Chairman*

The Public Relations Committee has had a busy year. The seeds of public relations work sowed in previous years has been bearing fruit. So, once again the character of our work begins to change. A few years ago the threat of socialized medicine caused us to sit up

and take account of our assets and liabilities. We were forced to admit our shortcomings and do something about them. During the past few years the work of your Public Relations Committee was aimed at improving relations between doctors and the public throughout the state. This has been done to a certain extent through State Fair Exhibits, courses for medical assistants, medical exhibits, films, distribution of AMA information booklets, liaison with newspapers, radio and television programs, Hospital and Medical Press Codes, and especially by the Medical Forums. A great many of the societies continued to present Medical Forums during the past year with very satisfactory results. No exhibit was held at the Southeastern Fair this year because of the difficulty in staffing such an exhibit. We feel that exhibits are very worthwhile, but having someone in attendance at all times presents a hardship.

Last year it was planned that a Public Relations program would be more effective if directed on a district or regional basis. This would in no way lessen our efforts to strengthen the local societies. Therefore, throughout the year meetings have been held in each of the districts. To these meetings, the President and Secretary of each society in the region has been invited. The basic format was:

- a) Explain the basic requirements for a county society.
- b) Present to each county society a "Minutes Book," especially prepared for that society and containing a copy of the Charter.
- c) Stress the importance of linkage, not only between societies but between societies and the Association.
- d) Stress the need for and present a definite plan for Public Relations for each society.

Now, each district has been visited and each society presented with its Minutes Book. The Executive Secretary or Field Secretary, or both, has always been present and a manual on Public Relations prepared by the American Medical Association has been presented to the President and Secretary of each society. After each meeting, time was spent in discussion of problems pertaining to the individual societies.

Television programs sponsored by the Medical Association of Georgia have been presented, and also forums were television under the MAG sponsorship.

During the past year the Public Relations Department has extended its activities to other Associations, with talks by our Executive and Field Secretaries and others to such groups as Chambers of Commerce, Kiwanis, Civitan, Rotary, etc. County societies have been urged to become active in these outside associations.

Intraprofessional services have been made available for specialty societies. At the present time there are listed some 16 groups of specialties for physicians within the state, and approximately half of these have made use of the services available through the Secretary's Office of the Medical Association.

Growing out of experience working with MAG committees and component societies it is apparent that this committee's program derives its main function in projects basic to these groups. The district

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¹Albertson, H.A. and Trout, H. H., Jr.: *Antibiotics Annual* 1954-55, Medical Encyclopedia, Inc., New York, N. Y., 1955, pp. 599-602.

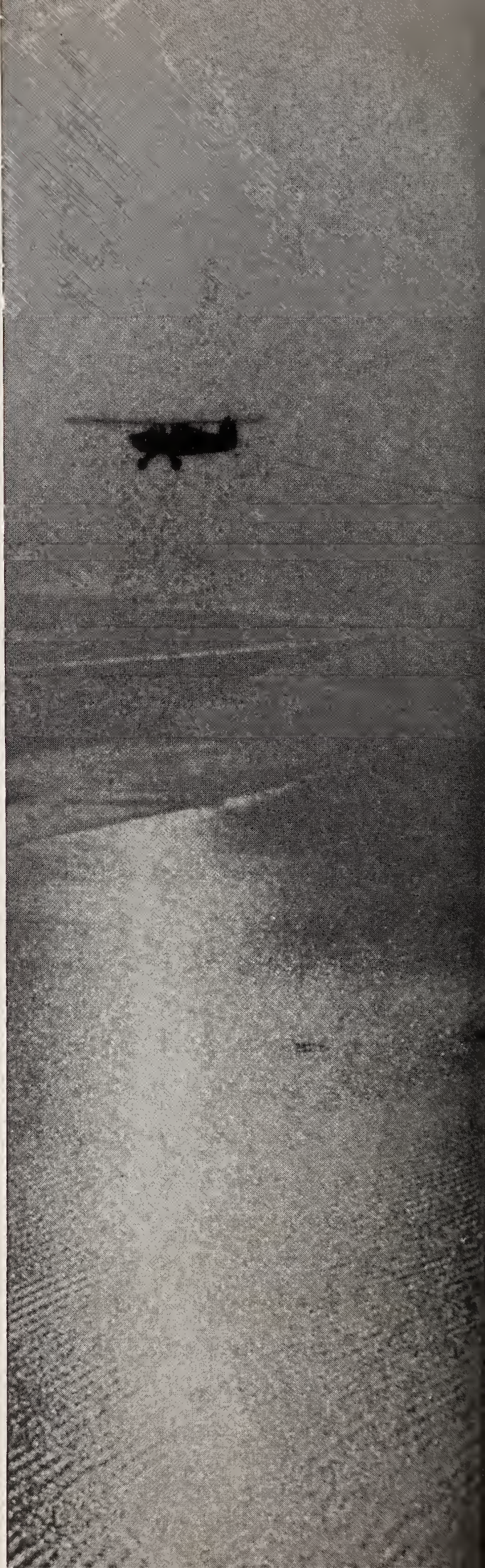
²Prigot, A.; Whitaker, J. C.; Shidlovsky, B. A., and Marmell, M.: *ibid*, pp. 603-607.



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and regional conferences have been so successful, and invitations to return have been so insistent, that it is planned to continue these conferences at grass roots as a service to the component society officers. The next move in the ever expanding program of this committee is to step away from the purely "Public Relations" attitude and establish a true "Public Service" aspect. This will eliminate the alleged self-gain to the physician which might accrue directly or indirectly from past Public Relations projects. Physicians will now support the initiation or furtherance of health projects that cannot in any way be construed as beneficial to the pocketbook of the medical profession. Projects under consideration for study and possible action include:

- a) Automobile and Highway Safety.
- b) Mental Health.
- c) Rural Health.
- d) Blood Banks.
- e) Improving Hospital Services.

The accent is now on SERVICE.

Reference Committee Recommendation—The report of the Public Relations Committee, Chris J. McLoughlin, Atlanta, Chairman, was approved, and the reference committee wishes to commend this committee for their excellent work.

House of Delegates Action—Recommended adoption of the Public Relations Committee Report as presented by the reference committee, which was moved, seconded and adopted.

Hospitals Committee

MILFORD B. HATCHER, *Chairman*

The Hospitals Committee of the Medical Association of Georgia has been reorganized during the year and has attempted to correlate its overlapping duties with the various agencies throughout the state which deal with hospital care.

A very close liaison has been established with the Georgia Hospital Association. It is felt that with friendly and close liaison with this and similar groups many mutual problems can be amicably worked out, where otherwise a stalemate might be reached from misunderstanding.

One of the big problems which has been created by the increase in the number of hospitals, especially in smaller communities, has been the lack of set professional standards, resulting in some undesirable criticism of the medical profession.

The following resolution was passed by the House of Delegates of the Medical Association of Georgia at a previous session:

"WHEREAS, the duty of the Committee on Hospitals of the Medical Association of Georgia is to study and improve the relation of the medical profession to the operation of public and private hospitals within this State; and,

WHEREAS, the Committee on Hospitals should confer with related agencies and organizations to further these objectives

THEREFORE, BE IT RESOLVED BY THE HOUSE OF DELEGATES OF THE MEDICAL ASSOCIATION OF GEORGIA, that approval be given to the recommendation of the Committee on Hospitals to create, on a state level, a joint commis-

sion to study and make recommendations concerning hospital standards in Georgia as these standards relate to the medical profession.

BE IT FURTHER RESOLVED, that this joint commission be composed of representatives of the Medical Association of Georgia; Georgia Academy of General Practice; Georgia Chapter, American College of Surgeons; and the Georgia Hospital Association."

In carrying out this resolution, the Hospitals Committee was reorganized and is composed of representatives of the Medical Association of Georgia, Georgia Academy of General Practice, Georgia Chapter of the American College of Surgeons, and the Georgia Hospital Association (physician members). This committee submits the following recommendations:

"That certain professional standards embodied in a code of hospital operation according to the size of the hospital should be set up and the Medical Association of Georgia should award certification to hospitals meeting these minimum standards in laboratory facilities, record maintenance, tissue examination, and staff surgical qualifications. Furthermore, that any hospital accredited by the Joint Commission on the Accreditation of Hospitals would automatically be awarded an MAG certification and that an effort be made to get more hospitals to be accredited by its joint commission. Furthermore, that the present Hospitals Committee serve in the capacity of the accrediting agency as members from the American College of Surgeons, Georgia Chapter Georgia Academy of General Practice, and Georgia Hospital Association were already members of this Hospitals Committee and that this committee in effect become a commission for accreditation and certification of hospitals as stated herein. Furthermore, that all members of this commission be duly licensed doctors of medicine."

This recommendations was unanimously approved at a meeting of the Hospitals Committee April 8, 1956.

Reference Committee Recommendation—The report of the Hospitals Committee, Milford B. Hatcher, Macon, Chairman, was approved after considerable discussion.

House of Delegates Action—Recommended adoption of the Hospitals Committee Report as presented by the reference committee, which was moved, seconded and adopted.

State Advisory Committee to the Selective Service System

WILLIAM G. HAMM, *Chairman*

The following is a resume of work carried on by the Georgia State Advisory Committee to the Selective Service System under my chairmanship during 1955:

This year was marked by the renewal of the "Doctor Draft" with the passing of Public Law 118 by the 84th Congress replacing Public Law 84. Although the Universal Military Training and Service Act was extended to 1959, Public Law 118 extended the Doctor Draft provisions only until July 1, 1957.

The most notable amendment of the Act reads as follows:

"No person in the medical, dental and allied specialist

categories shall be inducted under the provisions of this sub-section (A) after he has attained the thirty-fifth anniversary of the date of his birth, if he applies or has applied for a commission in one of the Armed Forces in any of such categories and is or has been rejected for such commission on the sole ground of a physical disqualification, or (B) after he has attained the forty-sixth anniversary of the date of his birth."

Such persons who were merely classified 4-F by their draft boards would not be affected by the new amendment. To be affected, a physician or dentist must have applied for a commission as a medical or dental officer in one of the armed forces and have been rejected on physical grounds.

The creation of an adequate pool of new graduates was stressed to meet the calls by the armed forces for physicians and dentists. In each case of an intern or resident the individual merits are considered, but in these cases it must be remembered that for every younger man held back a much older man might be called in his place.

In this connection we are advised that the needs of the military services for medical officers from July 1, 1956, to June 30, 1957, will be such as to require active duty of all interns and residents who have not already satisfied their military liability and perhaps some liable physicians of Priority III who are older and who may be established in practice. It will not be possible to support deferment for residency training except for those included in the Department of Defense's Residency Consideration Program, or perhaps some very exceptional case. Residents will be called by Selective Service as needed throughout the year unless they voluntarily obtain commissions.

A call for physicians was levied for March, 1955. Orders were issued to two Priority I physicians, one Priority II physician, and fourteen Priority III physicians under this call. The status of these Special Registrants was investigated and their essentiality or availability was considered by the committee. Another call for five physicians to be delivered during February, 1956, was levied by the Selective Service System. Orders were issued to two Priority I men, one of Priority II, and two of Priority III. The status of these physicians was also considered and recommendations made.

As of December 31, 1955, there are in Georgia eighteen Priority I physicians with Class II-A deferments. Eleven physicians of Priority II are deferred. Fifteen physicians of Priority I and six of Priority II hold reserve commissions but have not been ordered to active duty.

Each year we secure lists of the graduates of the State Medical and Dental colleges. Questionnaires are obtained from these men and records completed concerning them. They are advised of the functions of the Advisory Committee.

During the year 1955 the Committee considered the essentiality of 62 special registrant physicians and 18 medical reserve officers. The dental sub-committee considered the essentiality of some 25 special registrant dentists and two dental reserve officers. One

veterinarian was considered by the Sub-committee on veterinarians.

As notices are received of the pending release from active duty in the armed forces of physicians from Georgia, letters of welcome are written them offering any possible assistance in regard to training or relocating.

Our Committee will continue to serve in our advisory capacity to the best of our ability in cooperation with the Selective Service System and the Armed Forces, as well as with the Special Registrants and Reserve Officers of our State. Dr. David Henry Poer will carry on the work of the Committee as Chairman for 1956. Dr. L. Minor Blackford will serve as co-chairman. This is in accordance with the policy of rotating the committee chairmanship each year.

It has been a pleasure to serve as Chairman of the State Advisory Committee to the Selective Service System and I appreciate the excellent cooperation that has been shown by all members of this Committee.

Reference Committee Recommendation—The report of the Medical Advisory to Selective Service Committee by W. G. Hamm, Atlanta, Chairman, was approved.

House of Delegates Action—Recommended adoption of the Medical Advisory to Selective Service Committee Report as presented by the reference committee, which was moved, seconded and adopted.

Resolution on Sears-Roebuck Foundation

J. L. WALKER

(Habersham County Medical Society)

WHEREAS, the Sears-Roebuck Foundation through a generous grant in conjunction with the American Medical Association served the medical profession and the public at large with research and development in health activities; and,

WHEREAS, the Sears-Roebuck Foundation has specifically established a broad program in a "Plan of Assistance to Physicians Establishing Medical Practice Units"; and,

WHEREAS, the Sears-Roebuck Foundation prepared and distributed "A Planning Guide For Establishing Medical Practice Units" to augment their plan of assistance; and

WHEREAS, the Sears-Roebuck Foundation has rendered a sizeable amount of financial assistance to medical practitioners in Georgia under this plan during 1955 and will continue this assistance,

THEREFORE, BE IT RESOLVED, that the House of Delegates of the Medical Association of Georgia commend the Sears-Roebuck Foundation for this aid to Georgia medicine and the people of this State, and

BE IT FURTHER RESOLVED, that the House of Delegates so instruct our AMA Delegates to present a similar resolution of commendation at the June 1956 AMA House of Delegates meeting.

Reference Committee Recommendation—The resolution by J. L. Walker on the Sears Roebuck Foundation was approved.

House of Delegates Action—Recommended adoption of the resolution by J. L. Walker on the Sears Roebuck Foundation as presented by the reference committee, which was moved, seconded and adopted.

REPORT OF REFERENCE COMMITTEE NO. 2

Ruskin King, Chairman

(The following reports as presented to this reference committee are printed in full with the reference committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No 2 met in the Men's Lounge of the Academy of Medicine at 8:30 a.m., May 14, 1956. Present were Ruskin King, Savannah, chairman; M. F. Simmons, Decatur, vice-chairman; W. P. Stoner, Sylvester, secretary; A. G. LeRoy, Thomson; W. L. Pomeroy, Waycross; R. L. Denney, Carrollton; R. C. Major, Augusta; Roy L. Gibson, Columbus; and Grady N. Coker, Canton.

President-Elect

HAL M. DAVISON

It is becoming increasingly evident to me as President-Elect, that this preliminary training is necessary to acquaint anyone about his responsibility as President. Shortly after I began to attend the Council meetings there were two things very remarkable for me. The first was my ignorance concerning the business of the society and second, the actual service being rendered by the Council, the Executive Committee, and the officers of the Association. A lot of time is required, not only by regular meetings, but by extra called ones, but it is not only this time cheerfully given, but what would be called in our Ministry, a dedicated attitude toward our Society and our profession shown by these officers. Invariably from all of them for me there has been evidence of patience, kindness and friendship. For this, I am grateful.

I have attended the meetings of the Council, of the Executive Committee, and also the meetings of some of the other committees. With the President or as his representative I have attended some of the local medical meetings over the state. We have always received a wonderful welcome. The meetings have been of high caliber. Our local societies are not only excellent but are going better with higher standards all the time. The scientific programs have been interesting, stimulating and instructive. The social affairs have been most enjoyable.

At the request of Dr. Chambers, Chairman of the Council, I substituted for him as a representative of the Medical Association of Georgia at the Annual Congress on Medical Education and licensure in Chicago. Much takes place in such meetings which is of interest and value to us and it is preferable that we should have this knowledge by direct contact. The Secretary of the Medical Association of Georgia, being the only continuing member of our governing body, should attend all such meetings. In addition, it is desirable for either the Chairman of the Council or his representative, to also attend.

If President-Elects to come may be presumed to be as ignorant as I proved to be, I may advise them

to seek a briefing from the Secretary and from the Executive Secretary to start with.

Once again, I want to express my appreciation and my thanks to the Council and other officers, both for the work they are doing for our society and for their attitude toward me personally.

Reference Committee Recommendation—It is evident that the President-elect, from his report, has been preparing himself well for assumption of his high office. Reference Committee No. 2 congratulates Dr. Davison on his industriousness and eagerness to be prepared for his duties as president of the Medical Association of Georgia. We agree that our secretary should attend all national meetings at which his presence would be helpful to the Medical Association of Georgia. We wish for Dr. Davison a pleasant and successful term of office.

House of Delegates Action—Recommended adoption of the President-elect's Report as presented by the reference committee, which was moved, seconded and adopted.

Fourth District Councilor

J. W. CHAMBERS

The Fourth District has in the year 1955 had a good year insofar as organized medicine is concerned. As you will note later in the membership report, there has been a slight loss in membership in the Fourth District for the year 1955 which has been primarily due to death and removal to other areas of practice. The Fourth District Society now meets twice each year. It had two meetings in 1955, both of which were excellent meetings. The Constitution and By-Laws for the District is in the process of being revised and at the next meeting will come up for final ratification.

Your Councilor regretfully reports that due to press of duties as Chairman of Council this year, he has not had as much time as heretofore to spend with the individual Societies in the District, but I assure you that this will be corrected in the coming year if at all possible. There have been no particular problems which have come to light in the Fourth District this year as they affect organized medicine in general. The spirit in the District is good, most of the men are interested, and in general the County Society meetings are reasonably well attended. However, some of the Societies need considerable help in improving their own organization and in completing revisions in their Constitution and By-Laws, as well as in the internal organization of their Societies.

FOURTH DISTRICT MEMBERSHIP

Counties	Members December 31, 1955		Members December 31, 1954	
	MAG	AMA	MAG	AMA
Clayton-Fayette	5	4	5	4
Coweta	19	5	18	3
Lamar	5	4	5	4
Meriwether-Harris	17	8	17	9
Newton	12	11	13	11
Spalding	34	29	33	30
Troup	37	32	41	33
Upson	17	13	20	15
TOTAL	146	106	153	109

Reference Committee Recommendations—Reference Committee No. 2 realizes that Dr. Chambers' duties as President of Council have cut stringently into the time he could allot to his position as Fourth District Councilor. We feel, though,

that his presence has been felt in the proceedings of the district.

House of Delegates Action—Recommended adoption of the Fourth District Councilor's Report as presented by the reference committee, which was moved, seconded and adopted.

Fourth District Vice-Councilor

CLARENCE B. PALMER

This Vice-Councilor is more familiar with the medical affairs of Newton and Rockdale Counties than with the rest of the district, so only these will be discussed.

The new Newton County Hospital, in Covington, has been open over a year now, having been opened for patients October 17, 1954. The bed rating is 34, and it averages about 60% filled most of the time, even sometimes having as many as 41 bed patients, by making single rooms double ones. There is an active staff, and meetings are held monthly ten months a year. The building can be expanded to a 50-bed hospital by simple extension of the two wings.

The Rockdale County Hospital opened not long after the Newton County Hospital. It is a county hospital, built with county and privately donated funds, and has a capacity of twelve beds. It is modern in every respect.

Reference Committee Recommendation—Reference Committee No. 2 commends Dr. Palmer for his report and expresses the hope that the two new hospitals in the Fourth District will operate successfully.

House of Delegates Action—Recommended adoption of the Fourth District Vice Councilor's Report as presented by the reference committee, which was moved, seconded and adopted.

Ninth District Councilor

W. BRUCE SCHAEFER

The Ninth District Medical Society shows a gain of three members over 1955. I think that 1956 will show even a greater gain of doctors because the Ninth District is growing. We have one of the most active medical societies, I think, in the State of Georgia. Meetings are held twice a year. Last meeting was held in Gainesville and was attended by approximately seventy-five doctors. The next meeting will be announced later in the Spring.

NINTH DISTRICT MEMBERSHIP

Counties	Members December 31, 1955		Members December 31, 1954	
	MAG	AMA	MAG	AMA
Banks	1	1	1	1
Blue Ridge	11	10	10	7
Chattahoochee	15	8	17	8
Cherokee-Pickens	15	10	14	9
Habersham	15	15	16	14
Hall	41	30	37	26
Jackson-Barrow	19	13	18	13
Rabun	3	3	4	4
Stephens	13	11	13	11
TOTAL	133	101	130	93

Reference Committee Recommendation—The Ninth District appears to be thriving in a medical way. We commend the district on its excellent attendance at meetings, and we commend Dr. Schaefer for his fine report.

House of Delegates Action—Recommended adoption of the Ninth District Councilor's Report as presented by the reference committee, which was moved, seconded and adopted.

Council of the MAG

J. W. CHAMBERS, *Chairman*

Your Council has, in all probability, in the year 1955 had the busiest and most complicated year in recent history of the Medical Association of Georgia. Numerous meetings have been required over and above the normal meetings which are scheduled quarterly. This has also been true of the Council Executive Committee. I should like to commend the members of Council for their diligence, for their interest and for their sincerity in carrying out their duties. I sincerely believe that Council has progressed to a very marked degree in carrying out the duties as assigned to it, through the Constitution and By-Laws and through the House of Delegates. Attendance at Council metings has been a very gratifying sight to all of us for the past year and it is significant that each Council meeting has been attended by either the Councilor or by the Vice-Councilor or both.

There have been a number of outstanding accomplishments which have occurred during this year and briefly, I believe they should be pointed out to the House of Delegates. One of the first accomplishments for the year 1955 has been the implementation of the Professional Liability Program as set up through the Insurance and Economics Committee. This program has been put into effect primarily through the field representation from the Headquarters Staff and at the time of this report over 700 of our members have enrolled in the St. Paul Mercury Professional Liability Program as sponsored by the Medical Association of Georgia since the inception of the plan, June 1, 1955.

Secondly, one of the grave problems that Council has been faced with during the entire year has been its continuing attempt to work out a reasonable solution to problems concerning the operational policies of the Eugene Talmadge Memorial Hospital. At the request of the House of Delegates, a Committee was appointed to appear before the Board of Regents with the Richmond County Medical Society's resolution as it was passed by the House of Delegates at its last meeting. This Committee prepared a careful report which was submitted to your Council and then subsequently met with the Board of Regents Education Committee on May 10, 1955. Then, on June 7, 1955, this special Committee and the entire Council met with the Board of Regents and presented our problem to them. We were well received, but subsequently the Board of Regents did not approve the recommendations as they were given them on June 7, namely, that professional pay-patients not be admitted to the Eugene Talmadge Hospital. Subsequently in September, Council sent representatives to the American Medical Association's Medical and Related Committees meeting in Chicago where the problem of teaching hospitals participating in the practice of medicine was again presented at their request. The report of the Medical and Related Committees activities has not been released as of this writing. At

its Council meeting in December in Thomasville, Council had the opportunity of hearing from Dr. George T. Harrell, Dean of the University of Florida Medical School, who kindly presented some of the problems and proposed operating policies of the teaching hospital of the University of Florida Medical School in Gainesville. This information was received by Council and subsequently a Committee met with Dr. Harrell to learn in more detail something of these proposed operating policies in the hope that they might give ideas that might be adaptable in helping work out our problem in Georgia. Throughout the year, Council has worked closely and given of its time and several special meetings in attempting to work out the problem of the operation of the Eugene Talmadge Memorial Hospital. More detailed reports of this will be presented to the House of Delegates by a Special Council Committee appointed for this purpose.

During the year, Council voted to provide County Societies with bound Minutes Books which contained their Charters, Constitution and By-Laws and provides means of keeping permanent minutes of their meetings. These have all been distributed to the County Societies and are serving a very useful purpose at this time.

Thirdly, a staff travel plan has been inaugurated which has been a great deal of help in providing better understanding between the Medical Association of Georgia, its Headquarters Office and County Society Officers and members throughout the State. Each component society of the Medical Association of Georgia has been visited at least once during this year. This has been of tremendous value in helping to promote, not only organization, but better liaison between the County Societies and the Medical Association of Georgia.

A "reserve fund" Committee of Council has been established and is now functioning. This committee is in the process of valuating our "reserve funds" and to ultimately make recommendations to Council and through it to the House of Delegates as to how reserve funds of the Association might best be invested or held on a long term basis. The Association's Headquarters Office suffered a rather damaging flood due to a torrential rain in Atlanta during the summer, which damaged the Headquarters Office and equipment to the extent of approximately \$1200.00. Repairs were made as quickly as possible so as not to hinder the function of the Headquarters Office, but many of the archives of the Association were damaged beyond repair and provisions have now been made to prevent a recurrence of such flood damage at any future date. It is impossible to be able to prevent such damage according to the administrative people in the government of the city of Atlanta who state that the possibility of such a flood will continue to be present because of certain drainage problems for that particular area. However, the equipment and archives of the Association have been re-

arranged so as to minimize any further damage in the event such a flood occurred.

Biographical and Application Data Forms were approved by Council to be sent out to the entire membership of the Medical Association of Georgia. Over half of our membership has responded at this time and these forms contain pertinent personal information which will be of a great deal of value to the membership when kept in our Headquarters Office. We sincerely hope that the remaining member will complete these forms and forward them in within a short time. Our *Journal* continues to be a source of pride for all of us in the Medical Association of Georgia. The *Journal* continues to be ranked among the top journals of the State Associations and its contents, typography and organizational section are good. Council voted during the year to reduce the subscription rate for the *Journal* to Interns and Residents to \$1.00 per year in order to make this *Journal* available to the numerous members of House staffs over the State. Dr. Woody and his staff are to be commended for their fine work during this year.

Your Chairman was appointed by Council to represent Council at a meeting in Chicago in October on the proposed amendments to the Social Security Acts in the National Congress in 1956. The meeting was attended by representatives of State Associations throughout the United States and was very instructive in regard to the various portions of House Resolution 7225. Subsequently, your Chairman also represented Council and appeared as a witness before the U. S. Senate Finance Committee in Washington in February of 1956. At a meeting in October of Council and the Legislative Committee, eight proposed legislative items were considered and submitted for study. Included in these eight items were registration of all physicians each year. Also, subsequently a committee was appointed to visit Senator George in person and discuss certain items of National Legislative importance with him and particularly his attitude and the attitude of the medical profession as it related to House Resolution 7225. This was done at the time Senator George was in Atlanta, and he was seen by Dr. William Harbin, Dr. Alex Russell, Dr. Hal Davison and your Chairman. After study, the Legislative Committee recommended that we actively support three of the proposed eight measures, namely, to repeal the act allowing for the practice of naturopathy in Georgia; an act to set up a Hospital Care Commission to study the problem of indigent patients over the State, and thirdly, legislation to amend the Enabling Act of the Talmadge Memorial Hospital. In December, the Executive Committee of Council had breakfast with Governor Griffin in regards to certain proposals for the coming General Assembly of Georgia. More detail of the legislative efforts of the Association will be found in the report of the Legislative Committee.

During the year, a Legal Counsel Committee of Council was set up to study the problem of the numerous requests for legal advice that are constantly

being made on our Legal Counsel. This committee has done good work and is still in the process of studying the problem. During the year, County Societies were encouraged to merge wherever counties were too small to function adequately and certain small societies have merged and this has been approved by Council in routine activity. A Cultist Committee was established early in the year by Council, and the report of this Committee will be found in the minutes of the December meeting of Council as published in the *Journal*. This Committee has done excellent work and its report is informative and interesting. Its recommendations are being studied at this time. During the year, the Constitution and By-Laws Committee requested the approval of Council to change the names of certain committees which that Committee felt would be in the best interest to the Medical Association of Georgia. These recommendations were approved: the Audit and Appropriations Committee, to be changed to the Finance Committee, the Hospital Committee to be changed to the Hospital-Relations Committee, and the Public Relations Committee to be changed to the Public Service Committee.

During the year, certain interprofessional Committees have been recommended to Council and these have been set up and are now functioning. An Inter-professional Council, composed of Doctors, Dentists and Druggists, has been set up with proper representation from the Medical Association of Georgia. Another committee which was set up by Council is a committee representing the Medical Association of Georgia, the Georgia Hospital Association and the Georgia Nurses Association to discuss and make recommendations concerning mutual problems of these Associations. This committee is now functioning. Also, there was set up, on action of Council, an Institution-Physician Relations Committee, which is now functioning, which has to do with the problems of physicians' relation in hospital situations; such as anesthesiologists, pathologists and roentgenologists. This Council committee is now functioning and a report subsequently can be expected from them.

Also during the year, Council has attempted to clarify the means of awarding the General Practitioner Award of the Year and the Hardman Award. These awards now are recommended by members over the state to a Council Committee. This Council Committee then carefully weighs the various names which are submitted for these awards and makes recommendations to Council. Council then votes on three awards, that is three names, to be submitted for the House of Delegates action in connection with these awards.

Finance. The Committee on Auditing and Appropriations has functioned conscientiously during the year. They have submitted a budget for the year 1956 which will be found in the report of the Council Audit and Appropriations Committee. The Association has operated well within its income for the year 1956,

and included in this report is the report of the Committee on Auditing and Appropriations as submitted by Dr. W. Bruce Schaefer, Chairman. Finally, your Chairman would like to express, on behalf of Council, its appreciation to all the many members who have worked during this year to make this a successful year. Members of our Headquarters Staff have all worked diligently and deserve an expression of thanks for their devotion to duty.

Reference Committee Recommendation—Reference Committee No. 2 commends Council for its diligent work during the past year, especially in the following: (1) professional liability program, (2) attempts to solve the problems of the operational policies of the Talmadge Hospital, (3) aid and support to the county societies, (4) investigation of the proper use of reserve funds, (5) commend the Council, and Dr. Chambers in particular, in representing organized medicine in Georgia in opposition to H. R. 7225, (6) for having set up several co-ordinating committees which proved to be helpful to the Medical Association of Georgia.

House of Delegates Action—Recommended adoption of the MAG Council Report as presented by the reference committee, which was moved, seconded and adopted.

ADDENDUM

Special Report on Talmadge Hospital Policy

(This is the report of the Special Committee appointed by the House of Delegates to present to the Board of Regents of the University System of Georgia certain objections to the operational plans of the Eugene Talmadge Memorial Hospital and the Medical College of Georgia.)

This body last May appointed a special committee to appear before the Board of Regents of the University System of Georgia. The purpose of the committee was to present and explain to that group objections that the Medical Association of Georgia had concerning certain features of the proposed operational plan of the Eugene Talmadge Memorial Hospital and the Medical College of Georgia. Council has instructed this committee to present a comprehensive report to the House of Delegates. This committee was further instructed by Council "that copies of the resume of the Eugene Talmadge Memorial Hospital controversy be sent to the Richmond County Medical Society for their consideration and approval before it is submitted to the House of Delegates."

Much effort, both on the part of this committee and Council, has been made. No action has been taken by the committee except at the direction of Council. How much has been accomplished only the future can tell. Very little is obvious at the moment. What shall be done next is, of course, left to this body to decide.

A brief historical review of this controversy is necessary. In March 1945, the Legislature of the State of Georgia passed the original enabling act. In this act the Board of Regents was empowered to "construct and operate a hospital for the indigent sick, or near indigent sick, in conjunction with the Medical College of Georgia." There was no indication in the early planning stages of this hospital that any patients other than the medically indigent were to be admitted. In 1952, after a lapse of several

years, funds were finally made available for construction of this institution and the planning committee began their work on the operational policies. It soon became apparent that a complete reorganization of the Medical College of Georgia would be necessary in order to meet the impact of this new situation. Up to this point, the planning has been under the supervision of the State Board of Health.

When it became apparent that a complete reorganization of the Medical College of Georgia was also necessary, a committee from the Board of Regents of the University System of Georgia was appointed. This committee sat with the committee from the Board of Health and with the administrative officers of the Medical College in the formulation of operational plans for the Medical College and the proposed hospital. It was very shortly realized that the joint operation of these two institutions by two separate state agencies was impossible from a practical and an administrative point of view, and the Board of Regents was finally prevailed upon to accept the responsibility of operating both institutions. The representatives on the committee from the State Board of Health continued to sit in on the negotiations in an advisory capacity, and the discussions were continued. These discussions continued through the summer of 1953. During these committee discussions the propriety of admitting patients who could pay a professional fee as well as pay for their hospitalization was discussed. There was never any unanimity of opinion on this subject; nevertheless, the Legislature of the State of Georgia in December of 1953 amended the Medical College Hospital Act and empowered the Board of Regents to operate in conjunction with the Medical College of Georgia a hospital for the benefit of indigent, near indigent, and pay patients.

Early in 1954, opposition on the part of the Medical Association of Georgia to the admission of pay patients in the Talmadge Memorial Hospital began to develop. At this stage, representatives of the Medical Association of Georgia were asked to sit in on the discussions in an advisory capacity, and the final operational plans essentially as approved by the Board of Regents on March 9, 1955, were evolved. Approval was given to these plans by this joint policy committee subject to the proviso that these plans should be found to be legal and ethical. In October 1954, the Richmond County Medical Society was asked to approve this tentative operational plan at a called meeting. This society approved the plan with the same proviso. In November 1954, the Council of the Medical Association of Georgia tentatively approved the operational plan again with the same proviso and called a special meeting of the House of Delegates to be held in Macon in December 1954 to consider this problem. However, when it became obvious to Council that the proposed plan, as approved by the joint policy committee, was in fact unethical and that in reality

it put the State of Georgia into the practice of medicine, Council withdrew its approval and recommended that the House of Delegates not approve the plan.

The Board of Regents of the University System of Georgia on March 9, 1955, approved the policy plan for the operation of the Eugene Talmadge Memorial Hospital.

One provision of that plan reads as follows: "RESOLVED FURTHER that the Board of Regents shall, and it does hereby direct, faculty members providing professional services to patients of the hospital to determine the charges for such services and to inform the chairman of their respective departments at the Medical College of Georgia of the charges. These charges shall be commensurate with the fees of the medical profession in the Augusta area. The board directs the chairmen of the departments of the Medical College to submit statements of these charges for professional services through the Comptroller of the Medical College to those patients receiving the professional services who are able to pay. The fees shall be paid to the Comptroller of the Medical College of Georgia who shall hold them in a special fund. Expenditures from this fund shall be made only upon direction from the Board of Regents. The board declares that this special fund shall not be used to compensate members of the faculty for duties in the care of the patients at the Eugene Talmadge Memorial Hospital or for their administrative and instructional duties at the Medical College of Georgia."

In April 1955, the Richmond County Medical Society again considered the operational policies of the Eugene Talmadge Memorial Hospital. The plans, finally approved by the Board of Regents on March 9, 1955, had been presented to the Richmond County Medical Society in their proposed form in October 1954. Approval was given by the Richmond County Medical Society at that time provided the plans were finally proven to be ethical and legal. However, in view of the action taken by the House of Delegates in Macon, in December 1954, and judging the plan to be unethical, the Richmond County Medical Society withdrew its approval. At this meeting an alternate operational plan was proposed for submission to the House of Delegates.

The House of Delegates in Annual Session on May 3, 1955, unanimously passed this resolution opposed to the above provision of the Board of Regents plan. This opposition is stated as follows:

"That the teaching programs of the Medical College of Georgia be developed and carried on through a full-time faculty of key administrative men. This full-time faculty will not be allowed referral practice in the Eugene Talmadge Memorial Hospital and no pay consultation privileges in other hospitals except State and Federal hospitals. These activities of the full-time faculty are to be limited by the President of the Medical College of Georgia in

such a way as to assure that proper teaching and research duties are not neglected."

"That no individual shall receive pecuniary profit from the admission of a patient to the Eugene Talmadge Memorial Hospital and the Medical College of Georgia shall be directed to operate the Eugene Talmadge Memorial Hospital with a closed staff that shall be composed only of the full-time and part-time faculty members of the Medical College of Georgia."

"That only indigent or medically indigent (staff pay) patients shall be admitted to the Eugene Talmadge Memorial Hospital except in case of an emergency or unusual circumstances, and that no fee for professional services be rendered or collected from patients in this institution."

Furthermore, at the same meeting of the House of Delegates a special committee was appointed to appear before the Board of Regents to present and explain the opposition of the Association to this portion of the plan approved by the Board of Regents.

On May 10, 1955, this special committee met with the Education Committee of the Board of Regents. At this meeting the following facts were stated:

"It is the earnest desire of our Association to be of all possible service to you in the operation of this hospital to the end that: (1) better training of medical students and nurses; (2) better training of residents who work in the hospitals; (3) rendering the best possible medical care to the sick people of Georgia be accomplished. In these main objectives there is complete agreement between the Board of Regents and organized medicine in our state.

There are only two points on which there is a difference of views between the Board of Regents and the Medical Association of Georgia.

I. The Board of Regents favors the admission of pay patients to the Eugene Talmadge Memorial Hospital. By pay patients here we have reference to those patients whose economic status would enable them to pay for professional services. It does not have reference to those patients who could only afford to pay for hospital service and, of course, does not apply to the wholly indigent.

II. The other point of difference is really a correlation of the first and that is, the Board of Regents proposes to make a charge for professional service to those patients who can afford to pay for professional services.

The Medical Association of Georgia opposes these two provisions of the operational policies approved by the Board of Regents March 9, 1955, for the following reasons:

I. According to the Code of Ethics of the American Medical Association, it is unethical for a member physician to sell his services to an institution. We quote from the Code of Ethics of the American Medical Association: "A physician should not dispose of his professional attainments or services to

any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit the exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people."

II. The Medical Association of Georgia feels that this would be a bold step in the direction of the socialization of medicine. When the state takes over the function of one organization in part, or in whole, it is conceivable that it might take over function of other organizations. In the case of medicine, except in certain areas, such as mental diseases and those of definite public health nature and military service, medical care should be left to the private industry of organized medicine where there is an economic solvency sufficient to enable the patients to pay for these medical services. Under the medical practice plan in operation in this country, medical care has reached the highest level anywhere in the world. State medicine or socialized medicine wherever practiced has been inordinately expensive and of a relatively low quality.

III. Many members of the Medical Association feel that it would permit of unfair practice for a staff member of the Eugene Talmadge Memorial Hospital with the added prestige of such appointment and without the additional cost incident to the private practice of medicine such as office and nurse expense, et cetera, to take patients from the channels of private practice.

IV. Furthermore, it is felt that in such a centralized hospital, if patients able to pay for professional service are admitted, would be unfair competition with many small hospitals over the state built at much local expense, staffed by competent physicians, and which are rendering a vital service in their communities. These hospitals now depend on the income from such pay patients to remain financially solvent.

V. There are very few services to be rendered in the Eugene Talmadge Memorial Hospital which cannot be duplicated in many of the other hospitals in our state. These few exceptions are covered in our resolution.

VI. To delete pay patients from the Eugene Talmadge Memorial Hospital will not materially lessen the worth of clinical teaching material in the hospital.

VII. The research program, funds for which were to be derived from pay patients, should not necessarily be done away with by our proposal. Funds from many sources are available to institutions for research where interest and capacity can be established.

IX. Should you see fit to accept this proposed change suggested by the Medical Association of Georgia, its members would feel that it would be incumbent upon every physician in the entire state to join hands with you to see that this hospital

develops to its highest potentiality of service to our people."

Again on June 7, 1955, the special committee and Council of the Medical Association of Georgia appeared before the Board of Regents together with the President of the Medical College of Georgia.

The discussion centered around that part of the plan of operation of the House of Delegates which states: "That only indigent or medically indigent (staff pay) patients shall be admitted to the Eugene Talmadge Memorial Hospital except in case of an emergency or unusual circumstances, and that no fee for professional services be rendered or collected from patients in this institution.

"This paragraph states the only major difference between your proposed policy of operation and ours. While we as a special committee and the Council as a whole can, and do, grant your concessions on minor points of difference as outlined in this communication, we have no concessionary rights granted to us on this major issue and therefore will have to stand or fall pleading and contending for it. A fundamental principle is involved here which we feel honor bound to preserve for ourselves and our posterity. In no sense, otherwise, do we wish to appear non-conciliatory. In protecting our interest at this point we feel that we are protecting the interest of all private industry, yours and ours alike. The Marxist line of approach to Socialism and Communism has always been to take over the control of the practice of medicine first and through this to hold to gradually take over other fields of service and industry. We sincerely hope that the time has not arrived for this creeping, engulfing and damaging form of Statism or Socialism to find root in our state. Certainly, we as a Medical Profession, are determined to resist it with all the legitimate force at our command.

We feel that the primary function of the Medical College is to train students at the undergraduate level and interns and residents at the post-graduate level to be able to render the best medical services to our people. In doing this, we do not feel that it is the prerogative of the medical colleges to infringe upon the domain of the private practice privileges of the medical profession.

To do so, we feel, is unethical on the part of those physicians who so participate in this infringement. They, we feel, are participating in the corporate practice of medicine.

Furthermore, we feel that such practice policies are socialistic in nature.

Such a policy is unfair to the practicing physicians of our state and unfair to the established hospitals of our state. Since they are thus deprived of a potential source of income by a competing state institution.

Also, as set forth in our previous argument to you, we feel that it is unnecessary for the state to render this service to those who can pay. Other hospitals with adequate facilities and other physicians with equal skill are available. Let us dissuade the

minds of any and all that this is to be a super hospital."

"Doctors have been accused of being selfish and therefore wishing to hold this segment of practice to themselves. We are contending for principles and not dollars. Again, it is a principle we are upholding.

"Gentlemen, there is another segment of thinking involved in this matter that directly concerns you as the governing body of the University System of Georgia. One division of this system stands to be helped or hurt, strengthened or weakened in its relationship to the doctors of this state. This is meant in no sense as a threat nor does it imply any idea of concerted retaliation, but being human as we are it stands to reason that the profession will feel that its prerogatives have been taken over in part by the state and its domain has been invaded without reason. Should this occur, that closeness between medical education and medical practice will suffer. Lines are being drawn and sides taken which will hurt the Medical College. On the other hand if conciliation is granted by you on a point that can mean so little to you, but is so fundamental to us, we offer you our warmest support to the Medical College and the hospital. You stand to lose along with us if we lose on this point. We stand to gain if you concede to us on this fundamental issue."

On June 7, 1955, the Board of Regents declined to approve the alternate plan proposed by the Medical Association of Georgia and reaffirmed the plan approved March 9, 1955.

On November 18, 1955, representatives of this special committee appeared before the Committee on Medical and Related Facilities of the American Medical Association in Chicago. The objections of the Medical Association of Georgia to certain of the proposed operational plans of this hospital were outlined essentially as given above to the Board of Regents. The concluding part of our presentation to the committee is as follows:

The facts and comments given above we hope will serve to convey to your committee how the Medical Association of Georgia has reacted to this threat of the State of Georgia to enter the practice of medicine. Whether such practice is illegal is for the courts to decide. It is understood that many parallel cases are now in the process of litigation. The American Medical Association says it is unethical: "A physician should not dispose of professional attainments or services to any hospital, lay body, organization, group or individual by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physicians for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people."

We feel that the American Medical Association should vigorously and unequivocally reassert its position on this point. By so doing, it would serve to (1) dissuade its members from participating in such prac-

tice, (2) encourage county and state societies to deal with its members who engage in such unethical practice, and (3) help to prevent constitutionally bodies from instituting such a plan and to remedy them where they already exist.

Furthermore, we feel that the American Medical Association should implore the Association of American Medical Colleges and the American Hospital Association to discourage such procedures from becoming a part of their plans of operation.

The American Medical Association Committee on Medical and Related Facilities gave an extensive hearing to our objections along with similar complaints from the states of Mississippi, Oregon and Colorado. As yet, the committee report has not been rendered but Dr. David Henry Poer, a member of this American Medical Association Committee, gives for your information the following statement:

"As a member of the American Medical Association Committee on Medical and Related Facilities, I can inform the delegation representing the Medical Association of Georgia who gave a presentation concerning the Eugene Talmadge Memorial Hospital operational policies on September 18, 1955, at the Drake Hotel, Chicago, that the information presented by the Medical Association of Georgia delegation together with material from other state medical associations was received by our committee. Our committee will render a final report to the House of Delegates of the American Medical Association in Chicago in June 1956."

The Council decided to introduce in the Legislature during the 1956 session an amendment to the Act of March 9, 1945, and amended December 12, 1953, authorizing the Board of Regents to construct and operate this hospital. This amendment would specifically forbid the admission of patients to the hospital who could afford to pay for professional services.

AN ACT

To amend an Act entitled "An Act to Authorize and direct the Board of Regents of the University System of Georgia to construct and operate a hospital for the indigent sick or near indigent sick in conjunction with the State Medical College, out of funds in the building trust funds or any other money that they may be able to procure; to repeal conflicting laws; and for other purposes.", approved March 9, 1945 (Ga. Laws 1945, p. 453), as amended by an Act approved December 12, 1953 (Ga. Laws 1953, November-December Session, p. 117) so as to provide that the Board of Regents, the Medical College of Georgia, and said hospital shall not be authorized to charge for medical or surgical services or as such to engage in the practice of medicine; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

An Act entitled, "An Act to authorize and direct the

Board of Regents of the University System of Georgia to construct and operate a hospital for the indigent sick or near indigent sick in conjunction with the State Medical College, out of funds in the building trust funds or any other money that they may be able to procure; to repeal conflicting laws; and for other purposes.", approved March 9, 1945 (Ga. Laws 1945, p. 453), as amended by an Act of the General Assembly of Georgia approved December 12, 1953 (Ga. Laws 1953, November-December Session, p. 117), is hereby amended by striking Section 1 and inserting in lieu thereof the following:

"Section 1. The Board of Regents of the University System of Georgia in the exercise of its public and governmental functions shall have power and is hereby authorized to lease, buy, build, construct, establish, contract for the use of, maintain and operate a general non-profit teaching hospital at Augusta, Georgia, which said hospital may be that hospital known as the Eugene Talmadge Memorial Hospital, now under construction, to be operated in conjunction with the Medical College of Georgia for the benefit of indigent, near indigent and pay patients, under such rules and regulations as to administration, maintenance, charges for hospital services, and general operations as may be prescribed by said board not in conflict with general laws of Georgia pertaining to fiscal operations of departments and agencies of the State provided nothing herein shall be construed to authorize the Board of Regents, or the Medical College of Georgia, or such hospital or any department thereof to engage in the practice of medicine or to authorize any charge for medical or surgical services rendered in such hospital or any department thereof. The General Assembly may, as a part of the General Appropriations Act, make specific appropriations for the operation and maintenance of said hospital and any annex or addition thereto independent of and in addition to any appropriation made for the University System or any other division thereof."

SECTION 2.

All laws and parts of laws in conflict with this act are hereby repealed.

A hearing before the Committee on Hygiene and Sanitation of the House of Representatives was held on February 1, 1956.

The Board of Regents was represented by Chancellor Harmon Caldwell, Mr. Roy V. Harris and Dr. Rufus Payne along with others. The Medical Association of Georgia was represented by most of Council with arguments offered by Dr. Hal M. Davison; Dr. Thomas W. Goodwin, Speaker of the House of Delegates; Dr. J. W. Chambers, Chairman of Council, and Dr. R. C. McGahee, Special Committee Chairman.

After the hearing the Hygiene and Sanitation Committee referred the matter to a sub-committee for further study. This bill, House Bill No. 283, was never withdrawn and was never reported out of the

committee for reasons that will follow. After it became obvious that House Bill No. 283 had such powerful opposition from the Board of Regents, this special committee made the one departure, and the only one, from the action taken by the House of Delegates in 1955 concerning the operational plans of this hospital. This departure took the form of a compromise which would allow the full time faculty members in this hospital to have private patients up to 20 per cent of their salary and the care of which would not exceed 20 per cent of their time provided the patients were billed by the physician.

While it was realized that this was a compromise on the fundamental issue involved, at the same time the amendment would place a limit on private patient privileges. Without this limitation there could conceivably be a higher private practice allowance.

The steps leading to this action, the amendment itself and its fate are covered in part in the minutes of the Council as given below:

"J. W. Chambers, LaGrange, Chairman of Council presiding, called the meeting held via a conference phone call, to order at 1:15 p.m., February 5, 1956.

"The following members of Council were present per telephone roll call: H. Dawson Allen, Milledgeville, President; Hal M. Davison, Atlanta, President-Elect; William P. Harbin, Rome, Immediate Past President; David Henry Poer, Atlanta, Secretary-Treasurer; George R. Dillinger, Thomasville; W. G. Elliott, Cuthbert; J. W. Chambers, LaGrange; Mark S. Dougherty, Jr., Atlanta; Henry H. Tift, Macon; D. Lloyd Wood, Dalton; Neal F. Yeomans, Waycross; and W. Bruce Schaefer, Toccoa.

"Other officers present included R. C. McGahee, Augusta, First Vice-President; Stephen W. Brown, Augusta, Second Vice-President. Also present was Thomas W. Goodwin, Augusta, Speaker of the House of Delegates, and Messrs. Milton D. Krueger and John F. Kiser of the Headquarters Office Staff.

Talmadge Memorial Hospital Constitutional Amendment Legislation

"Chairman Chambers, after giving a resume and allowing discussion by all members present, read the following proposed legislation drawn up as a proposed Constitutional Amendment for introduction into the 1956 Georgia General Assembly. The Constitutional Amendment reads as follows:

"BE IT RESOLVED BY THE GENERAL ASSEMBLY OF GEORGIA: Section 1. Article VIII, Section 4 of the Constitution is hereby amended by adding a new paragraph, to be known as paragraph 2 to read as follows:

"Paragraph 2. The Board of Regents of the University System of Georgia, or any other agency which in the future has jurisdiction of the Eugene Talmadge Memorial Hospital, is hereby authorized to allow the medical practitioners who are full-time members of the faculty of the Medical College of Georgia to treat pay patients in such hospital and is further authorized to allow such medical practitioners to charge and accept fees for their services from pa-

tients who are financially able to pay for such services. Provided further that said members of the faculty shall not collect more than 20 per cent of the amount of their salaries in any calendar year, nor spend more than 20 per cent of their time in any calendar year engaged in the treatment of such private patients. The above limitations upon the time such medical practitioners may devote to the care of professional pay patients and the limitation upon the amount that they can receive for such services shall be prescribed by the President of the Medical College of Georgia. . . ."

"Chairman Chambers then reported that the authorities in charge of the operational policies of the Eugene Talmadge Memorial Hospital, namely the Chancellor of the University System, the President of the Medical College of Georgia, and the Superintendent of the Eugene Talmadge Memorial Hospital, were reportedly in favor of such a resolution to be submitted as a constitutional amendment at this time.*

"Chairman Chambers then called for a roll call vote and the constitutional amendment was approved by the Council unanimously.

"The meeting was adjourned at 1:35 p.m."

"*Addendum to Council Minutes (Not a part of the official minutes): After this meeting adjourned it was learned on February 6 (1956) that the Chancellor of the University System and the President of the Medical College of Georgia were not in favor of any legislation being introduced in the Georgia General Assembly at this time. This information then negated the approval of the Council of February 5 of the constitutional amendment for introduction in the Georgia General Assembly, as it had been believed by the Council that this was to be a cooperative effort.

Subsequent to this information, it was later learned on February 9 that the measures proposed in the constitutional amendment were not necessary as Mr. Roy Harris informed our offices orally that it *would not* violate the present Constitution of the State of Georgia for medical practitioners to charge and accept fees for their services rendered on state property. Mr. Harris further informed our offices orally that these measures would be written into the present operational plan of the Board of Regents for the Eugene Talmadge Memorial Hospital and would be ready to be brought before the members of the Medical Association of Georgia by the time of our Annual Session, May 13-16, 1956."

As requested by Council, the above data were presented to the Richmond County Medical Society. Since this society had presented its views on the problem to the House of Delegates at the May, 1955, meeting it was voted to accept this presentation as information. This matter remains one of great concern to the members of the Richmond County Medical Society.

R. C. McGahee
Chairman, Special Committee

Reference Committee Recommendations—Received as information, and the reference committee commends the committee of Council, with Dr. McGahee as Chairman, on the tremendous amount of work they have done on this subject during the past year as contained in this special report on Talmadge Hospital Policy.

House of Delegates Action—Recommended adoption of the addendum to the Council Report concerning the Special Committee on the Talmadge Memorial Hospital Policies as presented by the reference committee, which was moved, seconded and adopted.

Medical Education Committee

EDGAR R. PUND, *Chairman*

The chairman of this Committee apologizes for the failure of having a meeting during the past year. This Committee was placed in a rather awkward position because of the difference in point of view of the majority members of the Committee to that shared by the members of the Council after they had rescinded their approval of the operational policies of the Medical College of Georgia and the Talmadge Memorial Hospital. Through the contacts of the chairman with Dr. Harry B. O'Rear, Dr. Hugh Wood and Dr. J. K. Quattlebaum, a majority of the committee, it became evident that this committee was not in accord with the action of the Council and House of Delegates. The chairman has therefore been embarrassed by this incongruous situation and probably should have resigned. I had hoped, however, that a solution would be attained.

This Committee, for effectiveness, should not be controlled by the officials of the two medical colleges. There is no doubt a place for such a committee, but it should be composed of members of the medical profession who are not directly connected with the medical colleges in the State of Georgia. Matters concerning education could be referred to this committee and the administrative officers of the medical schools could be used in an advisory capacity. There are many other matters appertaining to medical education which could be brought to the attention of the Committee. It should take an active interest in making known to the laity, to the profession, to industry and to the foundations the medical educational needs of the State. Such a committee, not weighted with administrative officials of the medical schools, could well serve as an investigative and advisory committee for problems that arise in the Council and House of Delegates and could possibly lead to a more quiet discussion of these problems than has occurred in the past year. It would act as a mediator and clearing house for presenting factual information from the vantage points of the Medical Association and from the schools.

It is fair to state that this is not a report of the Committee on Education but an apologia on the part of the chairman for failure to call a meeting. The present committee was not called upon by either the Council or the House of Delegates to render service even though one of the most serious problems that confronted the Medical Association appertained to medical education.

Reference Committee Recommendation—Reference Committee No. 2 favors the establishment of a medical education program as provided in Section 3(b) in the proposed revision of the Constitution and By-Laws. (This revision was passed and is presently contained in the MAG Constitution and By-Laws.) This is in line with the suggestions made in the report of the Medical Education Committee of which Dr. Pund is Chairman. Reference Committee No. 2 is aware of the position in which Dr. Pund is placed and expresses the belief that such a situation will not continue to exist.

House of Delegates Action—Recommended adoption of the Medical Education Committee Report as presented by the reference committee, which was moved, seconded and adopted.

Cancer Committee

J. ELLIOTT SCARBOROUGH, *Chairman*

The Cancer Committee of the Medical Association of Georgia has held three meetings during the last year as follows: March 18, 1955, Sheffield Clinic; July 29, 1955, Emory University; January 27, 1956, Macon, Georgia.

The first two meetings were concerned with the problem of insufficient state funds to support the State Aid cancer program and serving in an advisory capacity to Dr. Murphy in this connection. The meeting on January 27, 1956, in Macon, Georgia, concerned itself with the establishment of a Cancer Registry system in all of the hospitals operating approved cancer clinics in order to meet the added minimal requirements made by the American College of Surgeons for approval of cancer clinics. As a result of this meeting a uniform Cancer Registry system has been set up through the cooperation of the American Cancer Society and the Cancer Control Division of the State Department of Public Health. Guidance will be provided for the cancer clinics in setting up and getting the program started.

The Cancer Committee has not been able to set up a program whereby the various established cancer facilities in the State could be visited with the hope of developing more cooperation and uniformity in the program. The Chairman believes that the establishment of the Tumor Registry System will go a long way toward accomplishing this.

It is hoped in the future that the full membership of the committee can be brought into closer focus with the purposes of our committee and also contribute to the protection of the public from unauthorized methods of treatment of cancer which have threatened our State in recent years.

The Committee has enjoyed the continued support of the American Cancer Society, Georgia Division, under Mr. Lon Sullivan and the Georgia Health Department under Dr. W. J. Murphy.

Reference Committee Recommendation—Reference Committee No. 2 commends the Cancer Committee on its efforts during the year, particularly in regard to the establishment of a uniform tumor registry system, and recommends to the House of Delegates continuation of support through the Cancer Committee of all agencies in the State cooperating for cancer control.

House of Delegates Action—Recommended adoption of the Cancer Committee Report as presented by the reference committee, which was moved, seconded and adopted.

Medical Civil Preparedness Committee

EDGAR M. DUNSTAN, *Chairman*

This year again the work of the Committee was intimately connected with that of the Medical Services Branch of the State Civil Health Services Division, which has been in operation since February 19, 1951. Our Committee is the main advisory group for this branch. Full minutes of the activities of this Branch are in the official files.

Representatives of this Committee attended the regular monthly school sessions and other meetings of this branch throughout the year and participated prominently in the following key activities:

1. Lectured on Georgia Civil Defense Medical Services Plan to the Public Health Civil Defense Laboratory Course given by the Communicable Disease Center in Atlanta July 18-23, 1955. Representatives from many states participated in this course.

2. Participated in the organization and instruction of the course on Catastrophic Injuries and Diseases instituted by the Emory University School of Dentistry as a regular course for senior dental students. This is now a regular 30-hour course in Civil Defense and represents the most complete course of its kind in the nation. Undoubtedly other dental schools will follow this example and we will thus soon have dentists scattered widely in many communities who can instruct other dentists in this vital work as assistant surgeons for civil defense.

3. Prepared two important papers:

a) *ROA and Civil Defense* presented at the annual June meeting of the Reserve Officers Association in Boston. The article outlined specific recommendations for utilizing the know-how of medical reserve officers in civil defense instruction. The Chairman of the Committee was elected National Surgeon of the Reserve Officer Association with instructions to implement this program.

b) *Proposed Creation of the Position of Deputy Director for Hospital Civil Defense in all Community Hospitals in Georgia*. The initial tentative draft was presented at the October 3, 1955, meeting of the Georgia Civil Defense Health Services School and the revised draft was presented at the annual February meeting of the Georgia Hospital Association.

4. Advised extensive distribution of the Obstetrical Manual and Personal Kit prepared by Dr. R. A. Bartholomew for Care of Obstetrical Patients in Civil Defense Emergencies.

5. Participated in the coordination activities of the Implementation Committee for Region Three (South-eastern States) of the Federal Civil Defense Administration.

6. Worked with the Civil Defense Emergency Hospital pilot project of Emory University—DeKalb County.

7. Is participating in the field testing of the Civil Defense 200-bed Emergency Hospital. It is planned to put on one of these demonstrations in connection with the 1956 annual meeting of the Medical Association of Georgia.

The Committee recommends that the 1956-57 Medical Civilian Preparedness Committee be composed of a physician from each of the six key civil

defense areas of the State, together with any other members-at-large which the president may wish to appoint.

Reference Committee Recommendation—Reference Committee No. 2 commends the Medical Civil Preparedness Committee on the work it has done during the past year. It is obvious a considerable effort has been put toward it especially by the Chairman, Dr. Dunstan. Reference Committee No. 2 approves the recommendation that a physician from each of the six key areas be appointed to this committee together with any other members at large whom the president may wish to appoint.

House of Delegates Action—Recommended adoption of the Medical Civil Preparedness Committee Report as presented by the reference committee, which was moved, seconded and adopted.

Resolution on Corporate Practice of Medicine by Hospitals

C. J. ROPER

(For Cherokee-Pickens Medical Society)

WHEREAS, it has been brought to the attention of the Ninth District Medical Society that an increasing number of hospitals in this state are entering, or attempting to enter, the corporate practice of medicine; and,

WHEREAS, this has been deemed detrimental to the private practitioner

THEREFORE, BE IT RESOLVED, that the membership of this Society go on record as being unanimously opposed to the corporate practice of medicine by any hospital anywhere.

BE IT FURTHER RESOLVED, that a copy of this resolution be introduced at the House of Delegates of The Medical Association of Georgia at its meeting in May 1956 to be made a part of the proceedings of that meeting.

Reference Committee Recommendation—Reference Committee No. 2 considered the resolution introduced by Cherokee-Pickens Medical Society on the Corporate Practice of Medicine by Hospitals. Reference Committee No. 2 feels that this resolution should be referred to the recently established Institution-Physician Relationship Committee of Council which is now functioning and which has to do with problems arising between physicians and hospitals.

House of Delegates Action—Recommended adoption of the resolution concerning the Corporate Practice of Medicine by Hospitals as presented by the reference committee, which was moved, seconded and adopted.

Resolution on Corporate Practice of Medicine

LESTER RUMBLE, JR.

(Fulton County Medical Society)

WHEREAS, in our State the basic tenets of the practice of medicine are being threatened under the guise of "Medical Education"; and,

WHEREAS, all previous attempts at settlement of this problem have met only with ignominious failure

THEREFORE, BE IT RESOLVED, that the Medical Association of Georgia employ the services of the most competent legal counsel to study and advise the Medical Profession regarding the status of medical practice in the State of Georgia

BE IT FURTHER RESOLVED, that future action in regard to such matters as Medical Education, practice, and ethics be based solely upon such legal

advice, thus giving all members of the medical profession a single set of legal and ethical standards for medical practice

BE IT FURTHER RESOLVED, that the members of the Medical Association of Georgia serve and speak only on the advice of counsel.

Reference Committee Recommendation—Reference Committee No. 2 rejects the resolution in its present form concerning the corporate practice of medicine submitted by Fulton County. We feel that the employment of competent legal counsel would be a good move. Other portions of this resolution were felt by this committee to have been presented in a manner which is not clear.

House of Delegates Action—After discussion by Lester Rumble, Jr., Atlanta; Ruskin King, Savannah; and Stephen W. Brown, Augusta, and subsequent substitute motions which were not carried, a final substitute motion was voted to become the main motion and the substitute motion ruling that the last two paragraphs of the resolution (i.e.: "Be it further resolved that future action in regard to such matters as medical education, practice, and ethics be based solely upon such legal advice, thus giving all members of the medical profession a single set of legal and ethical standards for medical practice, and

"Be it further resolved, that the members of the Medical Association of Georgia serve and speak only on the advice of counsel.") be deleted, and that the resolution consist of only the following three paragraphs:

"WHEREAS, in our State the basic tenets of the practice of medicine are being threatened under the guise of 'Medical Education'; and,

"WHEREAS, all previous attempts at settlement of this problem have met only with ignominious failure.

"THEREFORE, BE IT RESOLVED, that the Medical Association of Georgia employ the services of the most competent legal counsel to study and advise the Medical Profession regarding the status of medical practice in the State of Georgia." This substitute motion consisting of the above three paragraphs was approved on motion duly made and seconded.

Resolution on Talmadge Hospital Operational Policy

J. W. CHAMBERS
(For MAG.Council)

WHEREAS, the problem of ethical operation of the Eugene Talmadge Memorial Hospital has been of great concern to the Medical Association of Georgia for the past several years; and,

WHEREAS, in the interests of medical education and medical practice in this state this problem must be resolved

THEREFORE, BE IT RESOLVED, that the Council of the Medical Association of Georgia, realizing its responsibility in this matter, wishes to submit the following recommendations:

(1) That the Council requests that the Medical Association of Georgia House of Delegates reiterate its conviction that the operational plan of the Eugene Talmadge Memorial Hospital, as approved by the Board of Regents, March, 1955, fails to meet the standards of medical ethics of the Medical Association of Georgia and American Medical Association in the following categories:

- (a) the plan violates the basic principles of the patient-physician relationship in that it interferes with the free choice of physician
- (b) the plan permits the possible exploitation of physicians on the faculty of the Medical College of Georgia for the pecuniary gain of the state

(c) the plan deprives the physician of a voice in the expenditure of funds derived from the professional services rendered.

(2) The Council further requests the House of Delegates of the Medical Association of Georgia petition the Board of Regents and the President of the Medical College of Georgia to take the following five steps in order to correct these deficiencies in medical ethics:

(a) Amend the Board of Regents operational plan of March, 1955, to permit professional pay patients to be referred directly by their doctor to the desired faculty member

(b) Amend the operational plan to allow faculty members to see patients in consultation in other hospitals, other than government hospitals when so requested

(c) Amend the operational plan to provide for physicians rendering services to professional pay patients as follows:

(1) Allow physicians to bill those patients directly

(2) Allow physicians themselves to collect the fees from those patients

(3) Allow physicians to voluntarily turn those fees so collected over to the Research Fund as provided for in their contracts.

(d) Amend the operational plan to provide that no full-time physician shall spend more than 20% of his time in the treatment of professional pay patients or collect from professional pay patients and turn over to the Research Fund more than 20% in excess of the amount of his salary in any calendar year

(e) Amend the operational plan to provide means by which faculty members turning money into the Research Fund shall be permitted to make recommendations and be consulted as to how such monies shall be expended

BE IT FURTHER RESOLVED, that there is great need for adequate legal counsel and advice by the Medical Association of Georgia on this problem, and it is therefore recommended that the Association employ the services of the most competent legal counsel to study and advise the medical profession regarding the status of medical practice in the state of Georgia; and

BE IT RESOLVED, that nothing in this resolution be construed to imply that the Medical Association of Georgia is taking any legal steps against any hospital, the Board of Regents, or any other agency or organization, but simply means that the House of Delegates believes that legal counsel and advice is needed in order to solve this overall problem of the corporate practice of medicine. It is further felt that matters pertaining to the field of medical ethics should be judged solely by the Medical Association of Georgia and its component county medical societies and that matters of law should be handled and judged by the Association Legal Counsel.

Reference Committee Recommendation—On the Talmadge Hospital Operational Policies as submitted by the Council of the Medical Association of Georgia, J. W. Chambers, Chairman, Reference Committee No. 2 accepts the resolution on the Talmadge Memorial Hospital policy as presented by Council and revised by this committee after consultation with Dr. Pund. The revised version reads as follows:

RESOLUTION

WHEREAS, the problem of ethical operation of the Eugene Talmadge Memorial Hospital has been of great concern to the Medical Association of Georgia for the past several years; and,

WHEREAS, in the interests of medical education and medical practice in this state this problem must be resolved

THEREFORE, BE IT RESOLVED, that this Reference Committee, realizing its responsibility in this matter, wishes to submit the following recommendations:

(1) That the House of Delegates reiterate its conviction that the operational plan of the Eugene Talmadge Memorial Hospital, as approved by the Board of Regents, March, 1955 fails to meet the standards of medical ethics of the Medical Association of Georgia and American Medical Association in the following categories:

- (a) The plan permits the possible exploitation of physicians on the faculty of the Medical College of Georgia for the pecuniary gain of the State
- (b) The plan deprives the physician of a voice in the expenditure of funds derived from the professional services rendered

(2) The Reference Committee further requests that the House of Delegates petition the Board of Regents and the President of the Medical College of Georgia to take the following steps in order to correct these deficiencies in medical ethics:

- (a) Amend the plan to provide means by which the wishes of physicians referring patients to the hospital will be respected in assigning those patients to the faculty members. It is understood that the staff, however, reserves the right to assign patients to such services and attending physicians as may best meet the needs of the patient.
- (b) Amend the operational plan to allow faculty members to see patients in other hospitals, other than government hospitals, when so requested by physicians, under extraordinary circumstances.
- (c) Amend the operational plan to provide means whereby physicians rendering professional services to patients may bill those patients directly. The patient will be instructed to pay such fees into the Research Fund at the Medical College of Georgia in the name of the physician who rendered the service.
- (d) Amend the operational plan to provide that in no fiscal year shall the monies collected from professional pay patients exceed 20 per cent of the amount of the combined salaries of the Medical College Faculty.
- (e) Amend the operational plan to provide means by which faculty members turning money into the Research Fund shall be permitted to make recommendations and be consulted as to how such monies shall be expended.

BE IT FURTHER RESOLVED, that there is great need for adequate legal counsel by the Medical Association of Georgia on this problem, and it is therefore recommended that the Association employ the services of the most competent legal counsel to study and advise the medical profession regarding the status of medical practice in the State of Georgia; and

BE IT FURTHER RESOLVED, that nothing in this resolution be construed to imply that the Medical Association of Georgia is taking any legal steps against any hospital, the Board of Regents, or any other agency or organization, but simply means that the House of Delegates believes that legal counsel and advice is needed in order to solve this overall problem of the corporate practice of medicine. It is further felt that matters pertaining to the field of medical ethics should be judged solely by the Medical Association of Georgia and its component county medical societies and that matters of law should be handled and judged by the Association Legal Counsel.

House of Delegates Action—After considerable discussion and debate by Lester Rumble, Jr., Atlanta; R. C. McGahee, Augusta; John Mooney, Statesboro; Thomas W. Goodwin,

Augusta, and Edgar R. Pund, Augusta, the House of Delegates recommended adoption of the revised resolution by the reference committee, which was moved, seconded and adopted.

On motion (Thomas W. Goodwin, Augusta—H. Dawson Allen, Jr., Milledgeville) it was moved, seconded and duly adopted that the House of Delegates commend Dr. Edgar R. Pund, President of the Medical College of Georgia, for his clear and succinct presentation on the problems of the operational policies of the Eugene Talmadge Memorial Hospital at this session of the House of Delegates.

REPORT OF REFERENCE COMMITTEE NO. 3

Robert H. Vaughan, Chairman

(The following reports as presented to this reference committee are printed in full with the reference committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 3 met in the MAG Headquarters Office, Academy of Medicine, at 8:30 a.m., May 14, 1956. Present were Robert H. Vaughan, Columbus, chairman; Rafe Banks, Gainesville, vice-chairman; Linton H. Bishop, Jr., Atlanta, secretary; H. B. Cason, Warrenton; O. K. Coleman, Cordele; W. C. Mitchell, Smyrna; Samuel E. Patton, Macon; and Ralph H. Chaney, Augusta.

Secretary

DAVID HENRY POER

Membership: Membership figures for the year ending December 31 are as follows:

Active	2291
Associate	159
Honorary	2
Scientific	7
Life	215
	<hr/>
	2674

It should be noted that there has been a healthy increase in membership of the Association due to the fact that more physicians are entering practice in the state and all are joining their local societies. This speaks well for our county societies and also for the advantages that this state has to offer the young physician, be he generalist or specialist. Apparently all older physicians who are qualified and desirable have been approached in regard to membership and few, if any, are not enrolled.

Association Headquarters: As the organization of the Association has reached a more mature stage of development we can now determine our needs for the future with greater accuracy. Staff personnel now includes six full-time and two part-time salaried members, and on occasions temporary assistance has been necessary. When one considers that separate departments such as the Annual Session or any one of several major committees require almost full-time secretarial assistance the year round, then the activities of the Association Headquarters Office are limited only by the number employed. Our greatest need now is to organize our Public Relations Department on a

more formal basis because the needs of the medical profession for better relationships with the public were never greater. Hospital and professional relations are daily assuming greater importance and our committee in charge of these ethical problems is just getting under way and will need assistance. The same might be said for our Rural Health and other committees, but it seems better to proceed slowly with additional responsibilities. For these needs, one additional male secretary will be required, and this recommendation has been made to the Executive Committee and to Council.

It has become obvious to those of us working in the Headquarters Office each day that the saturation point has been reached in our present quarters and that in the near future additional floor space will be required. It has been noted also that the needs of our host society continue to increase so there is no room for expansion of either. The following resolution was presented by our distinguished preceding Secretary, and it met the unanimous approval of our members in 1942:

**Adopted by the House of Delegates Session,
Augusta, May 1, 1942.**

A RESOLUTION

"Whereas, the activities of the Medical Association of Georgia have grown each year; and

"Whereas, there should be established a permanent headquarters office for the routine business of the Association, for the preservation of the archives of the Association including medical history; and for a medical package library service for the benefit of both the medical profession and the public; and

"Whereas, the finances of this Association are now favorable to the development of such a plan; and

"Whereas, this year—1942—marks the hundredth anniversary of Dr. Crawford W. Long's discovery of the anesthetic properties of ether; and

"Whereas, it would be appropriate for this Association to honor the memory of its most distinguished deceased member—Crawford Williamson Long—by naming the proposed building the Crawford W. Long Memorial Building; therefore

"Be It Resolved, by the Council of this Association and the same is recommended and transmitted to the House of Delegates and the Association in general session, at Augusta, this May 1, 1942, that the Medical Association of Georgia develop, through its Council, plans for a permanent headquarters building for the Association, and that the sum of Five Thousand (\$5,000) Dollars be set aside by the Association's Secretary-Treasurer to be known as the Building Fund, the fund to be added to from year-to-year as the Association directs until a sufficient amount is available to facilitate a suitable building program. . . .

**Proposed by Dr. Edgar D. Shanks, Secretary-Treasurer . . .
Adopted."**

The same needs have been met by other state associations in this area by construction of office type buildings without an auditorium. The MAG has been able to put aside funds each year for this purpose and it is established that the balance required can be amortized over the next 20 years (or less). One southwestern state with only 1,600 members raised the necessary funds by a simple assessment of only \$35.00 per member, and it is probable that a small amount would be needed in Georgia. It is recom-

mended that the House of Delegates approve the idea in general and that Council be authorized to investigate this problem further, and to make such preliminary surveys as may be required.

Legislation: On a national level our Association is being called on much more frequently to use our influence in Washington in regard to the passage of laws not in the best interests of good medical practice. All members perked up their ears sharply when Mr. Truman's memoirs frankly stated that the one great disappointment of his administration was his inability to bring about socialization of the practice of medicine. Even though administrations have changed in name, efforts continue to bring about changes particularly in the social security set-up, all of which want to put the practice of medicine in politics and put unfair burdens on the shoulders of physicians. Our efforts along these lines must continue to support the fair and comprehensive policies of the AMA.

On a state level, our most serious need is a medical practice act that will permit some degree of control by the State of the various healing arts for the best interests of the sick and injured citizens of Georgia. The present act was written in 1913 and nothing but rather minor amendments have been made in it since that time. At the present time it seems doubtful that the license of any physician practicing in the State could be removed for any cause except conviction of a major crime, and indeed, it has been said that some men practicing without a license could not be restrained. As guardians of the health of Georgia citizens it is our duty to lend our assistance to the Medical Examining Board of the State to see that these conditions are corrected. It is recommended that Council investigate this situation thoroughly and propose methods in cooperation with the Medical Examining Board that will give Georgia a fair and enforceable Medical Practice Act.

The assistance of our members who are also members of the legislature has been invaluable but it is felt that we put an unfair burden on them by asking them to serve as our Legislative Committee. After all, these men may have political commitments that make it difficult to "serve two masters" and it is recommended that they be asked in an advisory capacity only.

Corporate Practice of Medicine: Since the summer of 1954, much has been heard in Georgia about the corporate practice of medicine, particularly by the State of Georgia in the operation of the Talmadge Memorial Hospital (See Special Committee Report). Our interest in this matter widened rapidly following the court decision in Iowa in December in regard to all hospitals' being engaged in the practice of medicine who have salaried physicians on their staff and collect fees for their services. This matter is assuming major proportions and soon will effect the practice of medicine of a large majority of physicians in Georgia. In my mind, a clear decision must be made

in Georgia defining the corporate practice of medicine and it is recommended that Council be directed to determine this point in the near future. No doubt this will require special legal counsel and MAG Council should be authorized to employ such if deemed advisable.

Staff Medical Boards: It is the duty of the medical associations in most states to assume responsibility with state officials in the appointment of all Boards, commissions, and similar groups that carry out work relating to health matters. This is not true in Georgia due perhaps to our own ineffectiveness in medicopolitical matters in the past. At the present time, the MAG has no part in the formation of any State Boards except the Board of Health and indirectly (minority) of the Medical Education Board. There has been some negligence on the part of our own Association in providing nominees for the Board of Health and apparently many members do not consider this selection to be a serious duty. It seems to me that the House of Delegates should decide this matter finally for the Association, and that we should be governed accordingly. If district societies do not provide nominations as required by law, then Council should be directed to act for the Association.

Unfortunately, the present State Board of Health is illegally constituted due to two explained causes. First, the Governor made three illegal appointments to the Board in total disregard of the laws of the State. Secondly, and this is hardest to understand, three members of the MAG, all of them fully cognizant of the legal requirements, accepted appointments that had been made illegally. These men did not have the approval of their local or district societies and such methods certainly do little to promote harmony in the activities of this important department. Would it not be in order for the House of Delegates to openly disapprove such actions and request that our members follow proper legal proceedings? This matter has been called to the Governor's attention and hope exists that he will adhere to our State Laws.

Council: Never in the history of this Association has this official body handled so much important business in such efficient manner. This has required a large amount of the time of Councilors and Vice-Councilors who attend 75 per cent of the meetings. Others, including your officers, and the Chairman of Council and members of many other important committees have devoted an even larger amount of their invaluable services. It would seem that, at least some day, the Association could at least take care of a portion of their traveling expenses and perhaps provide a small per diem similar to other organizations who put great responsibilities on their officials.

MAG Program for 1956-57: In the past, organized medicine has so frequently been required to act in opposition to certain changes in health and welfare legislations, and to other matters of general interest as well, it is now our opinion that the MAG should

come forward to a positive program of items that we favor. At the last meeting of Council (March 17, 1956) the following recommendations were approved and are referred to the House of Delegates for action:

1) **SAFETY PROGRAM.** The Association should actively sponsor a program concerning increased safety on our streets, highways and homes. This would include prevention of auto accidents, first-aid, improved transportation of the injured and the treatment of injuries including shock. This program should be carried out in cooperation with other state groups such as PTA, Farm Bureau and labor unions.

2) **RURAL HEALTH.** Through no fault of the members of the Committee, the Association has not had the man-power to effectively carry out much of the work in this field. Actually the Association found itself in the position of sponsoring two different groups carrying out much the same program in that we contributed much of the financial support of the Better Health Council. Now an effective agreement has been reached with this group which also (and due to the persistent efforts of its efficient President, Mrs. Bruce Schaefer) has very substantial financial support from other sources and this has permitted them to employ a full time Field Secretary. It is recommended that the medical members of the Better Health Council make up the Rural Health Committee to insure complete cooperation of these groups.

3) **MENTAL HEALTH.** A full program has been planned in this field (See report of Committee on Mental Health).

4) **BLOOD BANKS.** A full program has been planned in this field (See report of Committee on Blood Banks).

5) **HOSPITAL AND PROFESSIONAL RELATIONS.** A full program has been planned in this field (See report of Committee on Hospital-Professional Relations).

It is recommended that the House of Delegates give its approval to the above program.

Miscellaneous Items: (a) Annual Session Meeting Place. As the total registration of members and guests increases each year, it is becoming obvious that facilities are not available anywhere in Georgia except in Atlanta. Even here, no one hotel can really contain the entire meeting when meeting rooms are needed for more sections each year. The number of commercial exhibits this year is exactly three times the number that we had in 1951 and this source of revenue is seriously cut down when exhibit space is not adequate in other Georgia cities. The President's Dinner has outgrown the facilities of the Biltmore and hotels in other cities. Several suggestions have been made:

1) To convene the meeting in Atlanta at least every second year;

2) To "tailor" the program to the limited out-of-Atlanta facilities by having only one or two sections meeting on any one day avoiding any "piling-up." This would prolong the program so that at least a week would be required and few physicians want to be away from their offices that long;

3) Another would be to have the House of Delegates meeting separately in advance of the Scientific Sessions so all business would be out of the way. Some preference should be stated by the Delegates to guide the Council.

(b) Councilor Districts. The tremendous size of the state will always make it difficult or actually impossible to avoid great distances in Councilor Districts. These now coincide with congressional districts which in turn were based on distribution of population 30 years ago. The Council of the MAG should give as fair and equal representation to all

physicians as is possible and this is not being done under the present system. Since the size of the average district society is approximately 100-200 members it would seem fair to give any county society with the same number of members a seat in Council. Any change of this type would require considerable study and it is recommended that the House of Delegates set up a special committee to carry out this duty and report to the 1957 Session.

Reference Committee Recommendations—The report of the Secretary was approved, with the suggestion that the matter regarding appointments to the State Medical Board be referred to the Legislation Committee if any further clarification of the law is needed. The MAG program in the Secretary's Report was approved with the reservation that special committees involved approve this program. The proposal to change the annual meeting to Atlanta every other year was disapproved as was the proposal to have the House of Delegates meet separately from the annual scientific meeting.

House of Delegates Action—Recommended adoption of the Secretary's Report with the qualifying recommendations presented by the reference committee, which was moved, seconded and adopted.

ADDENDUM

District Society Meetings

DAVID HENRY POER, *Secretary*

The Association Headquarters Office is striving for closer liaison with the district societies and has available facilities to aid in the planning of district meetings when so requested by the district society.

Some district society meetings as now scheduled conflict with other meetings of a similar nature which adversely affect attendance and programming, and I recommend that the Medical Association of Georgia Headquarters Office, when requested by district societies, work together with the district society program chairman or executive committee in planning district meetings.

Reference Committee Recommendation—Reference Committee recommends the adoption of the Addendum Report concerning district society meetings.

House of Delegates Action—Recommended adoption of the Addendum to the Secretary's Report concerning District Society Meetings as presented by the reference committee, which was moved, seconded and adopted.

Fifth District Councilor

MARK S. DOUGHERTY

The Fulton and DeKalb County Medical Societies stand at their highest membership and the societies are active and growing each year.

The Fifth District Medical Society met at the Academy of Medicine in November with Dr. Israel Steinberg of the Cornell Medical Center, New York City, speaking on the following title: "New Advances in Angio-Cardiography in Diagnosis and Treatment of Cardiovascular Disease."

The meeting was well attended. The following officers for the Fifth District Medical Society were elected: Dr. Chester Morse of Decatur was elected President. Dr. John Slade was elected Vice-President. Dr. J. H. Hilsman was elected Secretary. Dr. J. G. McDaniel was elected Councilor to the Medical Association of Georgia for three years. Dr. Charles S. Jones was elected Vice-Councilor from the Fifth

District Society to the Medical Association of Georgia for three years.

FIFTH DISTRICT MEMBERSHIP

Counties	Members December 31, 1955		Members December 31, 1954	
	MAG	AMA	MAG	AMA
DeKalb	51	50	50	45
Fulton	830	646	825	636
TOTAL	881	696	875	681

Reference Committee Recommendation—Report of the Fifth District Councilor was approved.

House of Delegates Action—Recommended adoption of the Fifth District Councilor Report as presented by the reference committee, which was moved, seconded and adopted.

Tenth District Councilor

H. L. CHEVES

The Tenth District shows an increase in membership of the Medical Association of Georgia and the American Medical Association, the increase being fifteen new members of the MAG and eight members to the AMA. We have had two meetings during the year both of which were fine meetings and fairly well attended, each one having about 20% of our membership. Several of the County Societies have been visited during the year and more would have been visited if the Councilor had received notification of when the meetings were being held. I cannot urge too strongly that the secretaries of the various societies include their councilor in their mailing list and notify them of each meeting.

One new society, the Oconee Valley, has been organized during the year. It has a membership today of fourteen and it is made up of members from Hancock, Morgan and Greene Counties. They are having regular monthly meetings.

Effort has been made in the past to combine Elbert, Franklin and Hart Counties into one society. I recommend that another trial be made to complete this organization. They will then have about twenty-seven members. The chart shows a separate society in McDuffie County and Wilkes County. This is true but these two counties combine for their regular monthly meetings and alternate between Thomson and Washington. A detailed chart below shows the status of each society.

TENTH DISTRICT MEMBERSHIP

Counties	Members December 31, 1955		Members December 31, 1954	
	MAG	AMA	MAG	AMA
Crawford W. Long	44	35	43	36
Elbert	17	9	17	10
Franklin	5	5	4	4
Hart	5	3	5	—
McDuffie	7	6	5	4
Oconee Valley	14	8	9	6
Richmond	202	156	195	153
Walton	11	10	10	9
Warren	2	2	2	2
Wilkes	13	8	15	10
TOTAL	320	242	305	234

Reference Committee Recommendation—Report of the Tenth District Councilor was approved.

House of Delegates Action—Recommended adoption of the Report of the Tenth District Councilor as presented by the reference committee, which was moved, seconded and adopted.

Medical Defense Committee

DAVID HENRY POER, *Chairman*

During the year 1955-56, as in past years, the Association attorney, Mr. John Dunaway, has represented many physicians under the membership privileges of medical defense. This year's activity in this area showed a marked increase and the Council and its Audit and Appropriations Committee studied the problem of better defined limitations of financial responsibility on the part of the Association in the members' behalf. It was concluded by the Council Legal Counsel Committee that the services of the Association attorney should be limited to prevent the apparent possibility of (1) the Association actively engaging in the field of professional liability insurance, and (2) the Association assuming "carte blanche" financial obligations beyond its ability of support.

The Council Legal Counsel Committee recommended that the Association provide legal consultation privileges only, when so requested by a member, and that this service as rendered by the Association attorney not exceed a charge of \$100.00 for any one member in any one calendar year. This recommendation was approved by Council and referred to the Constitution and By-Laws Committee. The recommendation is embodied in the proposed By-Laws revision to be presented to the House of Delegates at this session.

It is the Committee's recommendation that: (1) the House of Delegates accept the revision of Medical Defense privileges as presented in the report of the Constitution and By-Laws Committee, and (2) that members actively support the MAG program of professional liability now administrated by the MAG Insurance Board and approved by Council and the House of Delegates at the 1955 session.

Reference Committee Recommendation—After considerable discussion and clarification by interested parties, the Medical Defense Committee Report was approved.

House of Delegates Action—After considerable discussion a minority report was given by H. B. Cason of Warrenton concerning the coverage under the MAG Constitution and By-Laws for each and every member doctor. Dr. Cason then moved that the investigation of an assessment for every member for this type coverage be referred to the MAG Council for study. This motion was duly seconded and approved. Also the recommended adoption of the Medical Defense Committee report as presented by the reference committee was moved, seconded and adopted.

Woman's Auxiliary Advisory Committee

SHELLEY C. DAVIS, *Chairman*

The Woman's Auxiliary Advisory Committee met with the Executive Board of the Auxiliary in June 1955 and heard each state officer and chairman present her program plans for the ensuing year. Their proposed activities and plans were approved by the Committee with the hope that local County Medical Societies would support and augment the community health leadership of doctors' wives.

The Woman's Auxiliary to the Medical Association of Georgia is serving its parent organization well in relieving its members of many public responsibilities by accepting leadership in lay organizations and projecting the Association's desires in layman planning.

During the recent session of the General Assembly of Georgia, the assistance of the Auxiliary on the Naturopath bill cannot be overestimated. Their response to the Association's request to contact legislators was splendid and their attendance at the senate public hearing was gratifying. The Advisory Committee recommends that the Auxiliary County Presidents be added to the MAG mailing list for state legislation information so that they will be well informed when MAG again has occasion to call upon them for "grass roots" activity.

This Advisory Committee again met with the Auxiliary President in March 1956 to consider the request of the AMA Auxiliary for doctors' wives in Georgia to actively solicit funds from the public for the American Medical Education Foundation.

It was the considered judgment of the Committee that active solicitation from the lay public would be inappropriate at this time. It was felt that a fund appeal from doctors' wives in April would not be in the best public relations interests of the medical profession in Georgia. This Advisory Committee recommends to the Medical Association of Georgia that the AMEF Committee of the Association plan with the Auxiliary AMEF Committee a coordinated effort to improve and plan a contribution program for both doctors and their wives to support this worthy cause. Georgia has been fortunate in receiving \$117,000.00 for its two medical schools in the last three years when contributions have only totaled \$19,000.00. It is most desirable that our schools continue to be recipients of these funds. Thought should be given to some donation from each doctor's family in Georgia.

The Woman's Auxiliary has been a most cooperative group with which to work and deserves the commendation of the Medical Association for their support and service to the medical profession.

Reference Committee Recommendation—Report of the Woman's Auxiliary Advisory Committee was approved.

House of Delegates Action—Recommended adoption of the Woman's Auxiliary Advisory Committee Report as presented by the reference committee, which was moved, seconded and adopted.

Crawford W. Long Memorial Committee

LESTER RUMBLE, JR., *Chairman*

The report of this Committee is short. The results which have been obtained, partially through the activities of this Committee, have been published in the March issue of the Medical Association of Georgia *Journal*. During the past year, the \$25,000 allotted to the completion of the exterior and interior of the building in Jefferson, Georgia, has been spent and spent wisely. At the present time, the building is complete as regards basic necessities and is sound enough to last for many many years.

The problem which confronts your Committee at the moment is that of continuing to implement the purpose of this museum by planning the plaques, figuring, exhibits and so forth, which will become a permanent part of the memorial to Dr. Crawford W. Long. Those interested are invited to get in touch with the Chairman of this Committee.

Under our agreement with the historical commission, as of January 1, 1956, the Medical Association of Georgia has assumed the responsibility for maintaining the building. Thus the allotment of \$1,000 of this year's budget is being used for such things as water, lights, gas, and the maintaining of a caretaker for the property.

Reference Committee Recommendation—Report of the Crawford W. Long Memorial Committee was approved.

House of Delegates Action—Recommended adoption of the report of the Crawford W. Long Memorial Committee as presented by the reference committee, which was moved, seconded and adopted.

Mental Health Committee

RIVES CHALMERS, *Chairman*

This report is for the period March 10, 1955, to March 10, 1956. The report is divided in two sections: I—Committee Activities; II—Recommendations to the House of Delegates.

I. Committee Activities.

This Committee held two meetings of the whole Committee. In addition there were three meetings of sub-committees submitting recommendations for action by the whole Committee.

The first meeting was held on August 7, 1955, at the Milledgeville State Hospital and was attended by the following members: Drs. Rives Chalmers, Shannon Mays, George Alexander, T. J. Van Sant and Arthur Knight. Drs. Thomas G. Peacock and Guy Rice were present as consultants to the Committee. Dr. Peacock conducted the Committee on a brief tour of the State Hospital and gave us a picture of the tremendous problems involved in providing hospital facilities for 11,700 patients. There are approximately 40 physicians on the staff to supervise the care of these patients. There continues to be a problem of over-crowding, but recent addition of new buildings and repair of some old buildings has definitely improved the housing problem at the hospital. The Committee recognized the need for a better understanding of the problems of the State Hospital by members of the medical profession in Georgia.

At this first meeting the Committee agreed that we undertake two broad areas of functioning for this present year: (1) The formulation of a policy statement for adoption by the Medical Association in regard to the attitude of the doctors of Georgia toward medical care and treatment for the mentally ill; (2) The development of a program of continuing information for the members of the Medical Association relating to commitment procedures and care and treatment of those persons suffering with mental and emotional disturbances. A Sub-committee on Policy with Dr. J. R. Shannon Mays as Chairman, and a

Sub-committee on Continuing Information with Dr. Arthur Knight as Chairman, were appointed and requested to meet before the next meeting of the full Committee.

The second full Committee meeting was held on December 11, 1955, in Macon, Georgia, with the following members attending: Drs. Rives Chalmers, Atlanta; George Alexander, Forsyth; T. J. Van Sant, Marietta; P. T. Scoggins, Commerce; Arthur Knight, Waycross; Paul Schroeder, Atlanta; J. R. Shannon Mays, Macon. Dr. Thomas G. Peacock and Dr. Guy Rice attended as consultants to the Committee.

Dr. Guy Rice, head of the Division of Health Conservation Services of the State Health Department, presented the Mental Health Program of the State Health Department with the assistance of Mr. William C. Rhodes and Miss Florence Beasley of his staff. The Committee was impressed with the planning and development of the Mental Health Program and recommended that a special article describing this program be published in an early issue of the *Journal of the Medical Association of Georgia*.

The Sub-committee on Continuing Information made four definite recommendations which were approved by the full Committee.

1) That a Mental Health Page be included in the *Journal* similar to the Heart Page and Cancer Page. The subject to be of everyday interest to the practicing physician. This project was referred to the Council of the MAG and the Editor of the *Journal*.

2) That post cards with telegraphic messages on mental health subjects similar to those distributed by the Georgia Division of the American Cancer Society be mailed to each member of the MAG. This project is being investigated to get financial backing from the Mental Health Association.

3) That the Committee take responsibility for providing speakers on mental health at County and District Medical Society meetings throughout the state. The Georgia Psychiatric Association and other medical groups will be asked to cooperate in this project. The Committee will cooperate with the Women's Auxiliary in the preparation of Mental Health Programs for other professional and lay groups.

4) That the Committee investigate the possibility of preparing a booklet on commitment laws in the state in conjunction with the Georgia Bar Association, which would also include a brief statement of medical problems involved in commitment to be made available to the physicians of Georgia. (This booklet is being prepared in cooperation with the Georgia Bar Association and will be available in the near future.)

This meeting was attended by Mrs. R. M. Paty of Covington, Georgia, Chairman of the Mental Health Committee of the Women's Auxiliary to MAG. The Committee assured Mrs. Paty of our interest in the program of the Auxiliary and desire to cooperate with her in any way that we can.

The Sub-committee on Policy held two meetings. This Committee reached the following conclusions:

1) The function of the Mental Health Committee is to represent physicians in all branches of medicine in the promotion of mental health and to develop attitudes and policies regarding the prevention and treatment of mental illness in our state for adoption by the Medical Association of Georgia.

2) There are inadequacies in all phases of treatment pres-

ently available to persons suffering from mental illness in our state.

3) The physicians of Georgia have a deep concern for the persons suffering with mental illness in this state.

4) Each individual person suffering with any form of mental illness is entitled to the same quality of medical care and treatment as that afforded to any other sick person.

5) The establishment of screening or intensive treatment centers in designated areas of the state, especially in general hospitals with approved psychiatric facilities, can provide earlier treatment with better possibility of recovery. State subsidy for this program should be explored.

6) A study commission from the State Legislature should be created to study the present care and treatment of the mentally ill in Georgia with special attention to: (a) The proposed transfer of the State Mental Institution from the Department of Public Welfare to the Department of Public Health; (b) The means whereby facilities may be developed to increase the active psychiatric treatment available to each individual person suffering with mental illness; and (c) The development of a coordinated program of psychiatric research and training designed to attract more physicians to the study and practice of psychiatry in Georgia.

7) There is a definite need for change in commitment laws in this state so that persons suffering with mental illness can be treated as sick people, rather than offenders.

8) The creation of an intensive treatment team at the Milledgeville State Hospital under the direction of a well trained psychiatrist with proficiency in the areas of teaching and research is the best means of providing a nucleus for a training and research program. This program should be coordinated with the programs of training and research in the departments of psychiatry of Emory University School of Medicine and the Medical College of Georgia. This integrated program can make advanced psychiatric training available to the physicians of Georgia.

9) The organization of a Section on Nervous and Mental Diseases in the Program of the Annual Meeting of the Medical Association of Georgia will provide an opportunity for the presentation of scientific programs related to mental health for the membership of the Association. (Such a Section is being organized and will be included in the 1957 program of the MAG Annual Session.)

10) The establishment of committees on mental health in all the county and district medical societies in this state can be a means of promoting medical interest and leadership in the field of mental health.

11) The Committee assures the medical superintendents of the State Mental Institutions and the director of the Mental Health Division of the State Department of Public Health of the desire of the MAG to support them and to offer them our professional help in the study and resolution of their problems.

In addition to the above activities, the chairman of this Committee was privileged to attend a meeting of Mental Health representatives from State Medical Associations in Chicago, sponsored by the Council on Mental Health of the American Medical Association. This meeting revealed that the mental health activities of our association compare favorably with those of other state medical associations. We are all acting on the fundamental belief that the responsibility for leadership in the field of mental health rests with the medical profession and requires the cooperation and guidance of psychiatrists working closely with representatives of all branches of medicine to develop a broad program.

II. Recommendations.

In accordance with the above activities and con-

clusions, this Committee makes the following recommendations of the Medical Association of Georgia:

1) That the Medical Association of Georgia recommend to each county and district medical society in Georgia that a standing committee on Mental Health be created for the purpose of promoting an understanding of the problems related to care and treatment of the mentally ill and developing medical leadership for mental health activities in the community.

2) That the Medical Association of Georgia request the Governor of Georgia, or the State Legislature, to establish a Study Commission on Mental Health for the purpose of studying the care and treatment of the mentally ill persons in Georgia with special attention to:

a) The proposed transfer of the State Mental Institutions from the Department of Public Welfare to the Department of Public Health;

b) Means whereby facilities may be developed to increase the active psychiatric treatment available to each individual person suffering with mental illness in this state; and

c) The development of a coordinated program of psychiatric research and training designed to attract more physicians to the study and practice of psychiatry in Georgia.

It is further recommended that this study commission have representation from the following organizations: The House of Representatives and the Senate of the State Legislature, the Medical Association of Georgia, The Georgia Psychiatric Association, Georgia Association for Mental Health, Georgia Psychological Association, Better Health Council of Georgia, Department of Public Health, and Department of Public Welfare.

Reference Committee Recommendation—The Report of the Mental Health Committee was approved.

House of Delegates Action—Recommended adoption of the Report of the Mental Health Committee as presented by the reference committee, which was moved, seconded and adopted.

Headquarters Office Report

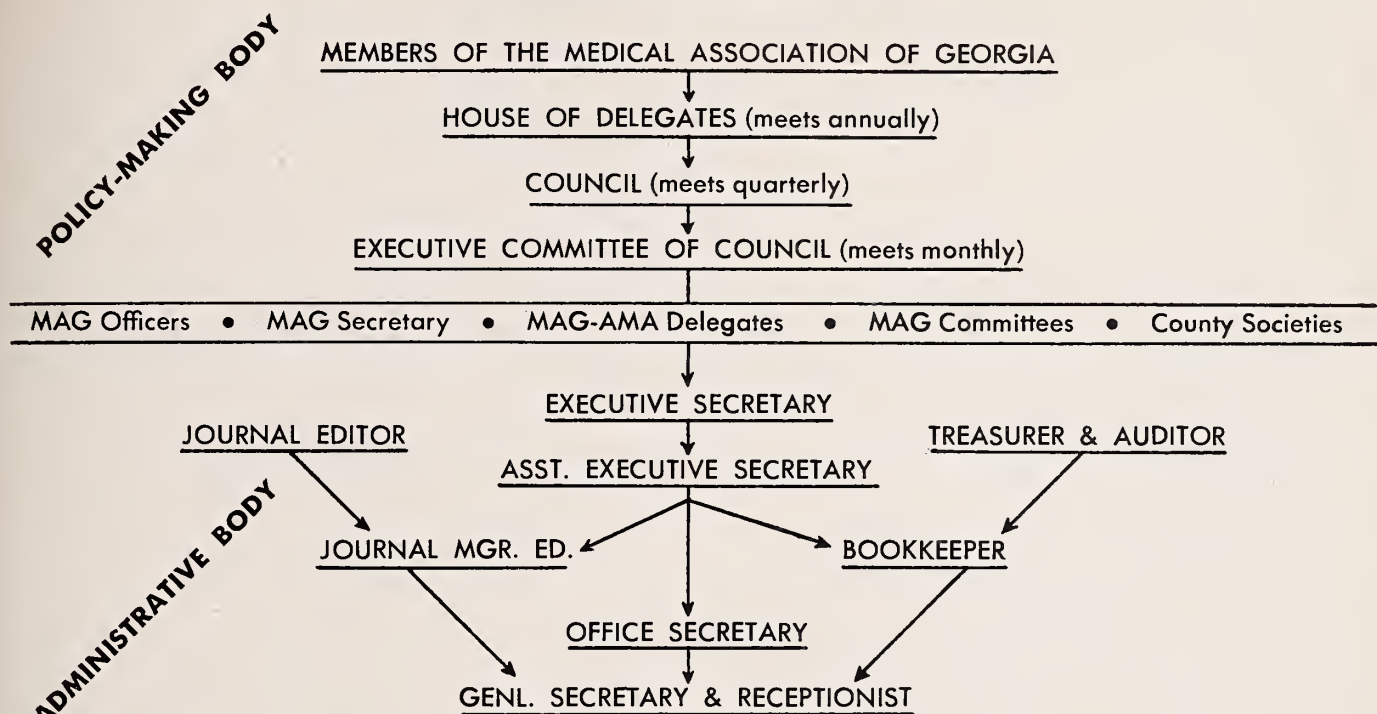
MR. MILTON D. KRUEGER, *Executive Secretary*

MR. JOHN F. KISER, *Assistant Executive Secretary*
Throughout its 106-year history, the Association has continuously sought "to promote the science and art of medicine and the betterment of public health," as set forth in the Constitution and By-Laws. New high levels of accomplishment were reached in practically every major phase of the Association's operations in pursuit of that aim during 1955-56.

Of special note are the following major projects carried out by the Headquarters Office during the year: Organizational Review; Increased Service to County Societies; Increased Service to Committees; and Improved Office Operating Procedures.

Organizational Review: The function of the Headquarters Office of the Association is to carry out the policies set by the House of Delegates, the Council and the Executive Committee of Council. In order to effect more business-like procedures within the Association, an organizational chart (See Figure I) was prepared, showing clearly the relationship between the governing bodies and the Headquarters Office. This matter is discussed further in the report of the Constitution and By-Laws Committee.

MEDICAL ASSOCIATION OF GEORGIA ORGANIZATIONAL CHART



Of course, in addition to serving the House of Delegates, the Council and the Executive Committee of Council, the Office works at the direction of the Association Officers, Committees and County Medical Societies.

Increased Service to County Societies: The year 1955-56 was marked by unparalleled activity on the part of the component county medical societies which constitute the Association. In addition, the Headquarters Office Staff redoubled its efforts to provide prompt and complete service to the component groups.

The staff assisted in preparing new (or revising old) Constitutions and By-Laws for practically all county societies. The existent societies were re-chartered and charters were issued to five new organizations. Minute books for county society secretaries were distributed by the staff in cooperation with the Public Relations Committee. The staff participated in ten different public relations conferences and for county society officers published a monthly Officers Newsletter with information relative to Association activities. An intensive visitation program was inaugurated with staff members attending each county society at least once a year.

Increased Service to Committees: Further progress was made during the year in providing complete secretarial and administrative assistance to the active committees of the Association. Of particular interest was the work of the staff in cooperation with the Pro-

fessional Liability Sub-committee of the Insurance Board and the Committee on Legislation.

The Headquarters Office staff assisted in organizing and coordinating a state-wide program of professional liability insurance in cooperation with a Sub-committee of the Insurance Board. The Executive Secretary acted as administrator of this long range liability program and in liaison with the St. Paul Mercury Company in establishing the basic foundations for the program which now includes one-third of the members and approximately three-quarters of the members who carry liability insurance. Slides were prepared showing the operation of the proposed program and staff members presented these slides at district and county society meetings throughout the State. In addition, staff members held conferences with the State and County Society Committees on Professional Liability Insurance.

An intensive state-wide legislative program was conducted this year under the guidance of the Committee on Legislation. Over half the members of the General Assembly were contacted personally by physicians and the Assistant Executive Secretary prior to the opening of the legislature in January. The three-point program, discussed in the Report of the Committee on Legislation was coordinated and implemented through the Office under the direction of the Assistant Executive Secretary. A Bulletin on Health and Medical Legislation was instituted in order to inform members of actions taken by the Gen-

eral Assembly in regard to bills of medical interest. *Improved Operating Procedures:* One of the primary objectives of the Headquarters Office is to provide adequate stenographic and publishing service to all members, and major changes were made in the physical plant of the Office toward this end. Mailings and general maintenance of records were streamlined by the acquisition of a dictating machine and a modern addressograph machine. A roster of members that indicated specialty, type of membership and county society was published with listings both alphabetically and by county society.

The staff assisted in a statistical survey conducted by the Maternal and Infant Welfare Committee and increased its service to the members of the Woman's Auxiliary. Organization and planning for the Annual Session was handled more efficiently than ever before with better liaison between specialty societies and the program committee. The staff is very proud of the great increase in the number of scientific and commercial exhibits that enhance the annual meeting.

Recommendations:

1) The Association should assume more of its responsibilities in the field of Public Service. Three or four Public Service projects such as Auto Safety, Mental Health, Rural Health, and improved Blood Banks which have already been endorsed by Council should be adopted by the entire membership. It is felt that the adoption of such projects would also greatly improve relations between the public and the medical profession in Georgia.

2) The House of Delegates should be informed that the steadily increasing activity of the Headquarters Office may require an enlargement of the staff, additional office equipment and office and conference room space and so recommend to Council to study this problem.

3) County Societies should be urged by the House of Delegates to improve their liaison with the Headquarters Office by sending in copies of society meeting minutes and more prompt notification of elections and other county society activities.

4) The House of Delegates should authorize the staff of the Headquarters Office to continue to actively establish closer liaison with medical specialty societies and related health agencies in Georgia in the interests of improved health and medical standards in the State.

Reference Committee Recommendation—The Report of the Headquarters Office was approved.

House of Delegates Action—Recommended adoption of the Report of the Headquarters Office as presented by the reference committee, which was moved, seconded and adopted.

The Journal

EDGAR WOODY, JR., *Editor*

MISS FRANCES H. PORCHER, *Managing Editor*

The 1955-1956 report on the status of the *Journal of the Medical Association of Georgia* follows the general plan of previous reports. Staff and policy, content, typography and format, and financial status are all covered under separate headings. As in the past, certain changes have been effected which will be outlined in the following report which the editor and managing editor submit.

Staff: David Henry Poer was named editor-in-chief by the Executive Committee of Council on December 17, 1955. It was stated at that time, however, that this appointment in no way alters the policy

or responsibilities previously designated to the editor. No other major changes have been effected in the overall organization of the *Journal*.

Upon his return from active service in the United States Navy in the fall of 1955, J. Willis Hurst, Emory University, was appointed as a contributing editor. Other contributing editors are Herbert S. Alden, Atlanta; Thomas Findley, Augusta; Charles S. Jones, Atlanta; Arthur M. Knight, Jr., Waycross; William H. Lippitt, Savannah; Arthur J. Merrill, Atlanta; Lester Rumble, Jr., Atlanta; Peter L. Scardino, Savannah; Patrick C. Shea, Jr., Atlanta; Henry H. Tift, Macon; and, Robert H. Vaughan, Columbus.

Two recommendations were made last year with regard to illustrations in the *Journal* and additional secretarial help. It is now the policy of the *Journal* to pay for three average-size illustrations per article. Any remaining illustrations are paid for by the author, as in the past. Some secretarial help has been obtained by utilizing the services of the second stenographer employed by the Medical Association of Georgia. This has been of considerable assistance in the handling of routine *Journal* business.

On November 7 and 8, 1955, the editor and managing editor attended the biennial Conference of State Medical Journal Editors and Business Managers, held in Chicago under the sponsorship of the State Journal Advertising Bureau of the American Medical Association. Many helpful ideas were gleaned from this session. Since that time, most of these ideas have been put into effect in the *Journal*. At this meeting, the *Journal* editor participated as a guest speaker outlining some of the problems and policies of the Georgia journal. Copies of this talk were sent to all members of Council and officers of the Association.

Equipment: In November a new addressograph machine was purchased by the Association to replace the obsolete machine formerly used. In the change-over, new addressograph plates were made to include on each one the following additional information: county society, membership status, and specialty. Bookshelves to house the archives of the Association (bound copies of the *Journal of the Medical Association of Georgia* since 1911) were built for the *Journal* office. Bookshelves for unbound copies were also constructed.

Content: The Doctor Placement Page has been dropped at the suggestion of the board of Contributing Editors, who felt that the information carried on this page was not of general interest to the readers. Such information is still obtainable from the office of the Executive Secretary of the Medical Association of Georgia.

In the October, 1955, issue, a case report was published with comments from two other physicians with special interest in this field of medicine. Other such case reports have been solicited because of the favorable comment this feature brought forth from the readers.

For the past eight months the names of new mem-

bers of the Association have been listed in the *Journal*. Also now included in the *Journal* are the lists, furnished by the State Board of Medical Examiners, of newly licensed physicians. For the second time, the *Roster* of members of the Medical Association of Georgia and of the Woman's Auxiliary to the Medical Association of Georgia has been published as a supplement to the *Journal*. This year, as in the past, the members of the Medical Association of Georgia were listed by county and alphabetically. This year for the first time each doctor's status of membership and specialty were included, in addition to the information carried last year.

Since the "personals" have been designated by districts, it is felt that more interest has been shown by the members in reporting their personal activities to the *Journal* office.

Recommendations: Because of the suggestion of numerous members for such information to be included in the *Roster*, it is recommended that the means be furnished whereby telephone numbers of member physicians as well as given names of their wives be included in future editions. This recommendation is made with full knowledge that the gathering of such information would entail considerable additional labor and expense.

Because of the past popularity of such feature pages as the Heart Page and the Cancer Page, it is recommended that all specialty societies within the State be invited and encouraged to support a feature page within the *Journal*. Because of the potential expense of such a plan, it is suggested that each specialty group be required to pay the cost of printing. **Typography and Format:** Subtle improvements in the *Journal's* format and typography have been made this year, but no drastic departures from the norm have been effected.

Probably the most noticeable change is the order in which the contents of the magazine are arranged. In the past, editorials and some feature pages preceded the original articles. In May a customary order to be used as a guide was set up as follows: (1) original articles (with a lead-in flag on the first page of the first article), (2) editorials, (3) features, (4) The Association, and (5) Information.

The page margins have been changed to comply with the rules of good design—with a resultant widening of the columns. Most of the information carried as a matter of record is set in smaller type to save space.

Continuations on right hand pages are now placed at the bottom of the page, for looks and readability.

Cover pictures now bleed on three sides instead of having a red bar at the bottom—this makes the cover illustrations show up better.

Advertising continues to be blocked in the back and front with the exception of the center spread preferred position. The additional revenue is the only reason for this.

More balanced folios are now in use—for appearance's sake.

At the Conference of the State Medical Journal Editors and Business Managers, all the state medical journals were evaluated by an impartial authority in the field of typography. Your journal was adjudged to be one of the two or three best journal (typographically) in the group. We hope that in 1957 the *Journal of the Medical Association of Georgia* will be the unquestionable *best*.

Financial Status: The *Journal* continues to sustain its printing costs with advertising revenue, and additional expenses are borne by subscription income. This is felt to be a favorable financial balance for any non-profit medical publication.

Reference Committee Recommendation—The Report of the MAG Journal was approved.

House of Delegates Action—Recommended adoption of the Report of the MAG Journal as presented by the reference committee, which was moved, seconded and adopted.

Resolution on World Medical Association

CHRIS J. McLOUGHLIN, M.D.

(Fulton County Medical Society)

WHEREAS, the World Medical Association is the only international organization formed for the purpose of representing the practicing medical and allied professions throughout the world; and,

WHEREAS, the World Medical Association is concerned with ethical, socio-economic, and medical education matters on an international level; and,

WHEREAS, The World Medical Association already has been effectively combatting socialism and is actively opposed to this idea in whatever form; and,

WHEREAS, the World Medical Association is not to be confused with the World Health Organizations; and,

WHEREAS, the World Medical Association needs the support of every practicing physician in the world;

THEREFORE, BE IT RESOLVED, that the Medical Association of Georgia be urged by the Fulton County Medical Society to appeal to all its members to join the World Medical Association and actively support its projects and programs.

Reference Committee Recommendation—Resolution regarding the World Medical Association was approved.

House of Delegates Action—Recommended adoption of the Resolution concerning the World Medical Association as presented by the reference committee, which was moved, seconded and adopted.

Resolution on AMA Dues

DAVID HENRY POER

(Secretary)

WHEREAS, it has been previously approved and recommended by the Council of the Medical Association of Georgia that individual Association members be strongly urged to voluntarily contribute to the American Medical Education Foundation; and,

WHEREAS, the financial support of AMEF has been left to the individual discretion of each physician on a voluntary basis;

THEREFORE, BE IT RESOLVED, that the

House of Delegates of the Medical Association of Georgia go on record in favor of this financial support of AMEF on a voluntary basis by individual physicians; and

BE IT FURTHER RESOLVED, that the House of Delegates of the Medical Association of Georgia oppose any compulsory assessment for this purpose and as such also oppose any raise in American Medical Association dues for allocation to the AMEF funds and that our AMA Delegates be so instructed.

Reference Committee Recommendation—Resolution regarding AMA dues was approved.

House of Delegates Action—Recommended adoption of the Resolution on AMA Dues as presented by the reference committee, which was moved, seconded and adopted.

Resolution on Marriage Laws

DONALD SCHMIDT

(Polk County Medical Society)

WHEREAS, the medical profession in Georgia is constantly striving to advance the art and science of medicine for the betterment of the health and welfare of the State and the community; and,

WHEREAS, a three day waiting period before the issuance of a marriage license would elevate sociological, moral and health standards in the State; and,

WHEREAS, such a provision in Georgia law would prevent "quickie marriages"

THEREFORE, BE IT RESOLVED, that the House of Delegates of the Medical Association of Georgia urge the Georgia General Assembly to amend the present marriage law to require that no marriage license shall be issued earlier than three days following the date of the application therefor

BE IT FURTHER RESOLVED, that the House of Delegates hereby instruct the Committee on Legislation to include this proposed amendment in its legislative program for 1956-57.

Reference Committee Recommendation—Resolution regarding marriage laws was approved.

House of Delegates Action—Recommended adoption of the Resolution on Marriage Laws as presented by the reference committee, which was moved, seconded and adopted.

Resolution on Sterilization

(Richmond County Medical Society)

WHEREAS, under the present sterilization law of the State of Georgia provision is made only for the sterilization of patients within State Hospitals; and,

WHEREAS, there are numerous instances of private patients needing or desiring sterilization for which no legal provision is made; and,

WHEREAS, the Richmond County Medical Society has approved an effort to remedy this lapse in legislation

THEREFORE, BE IT RESOLVED, that the Committee on Public Policy and Legislation of the Medical Association of Georgia seek the enactment of appropriate legislation whereby private physicians will be adequately protected by law when private patients under stipulated conditions may be sterilized for the betterment of the State and/or the Family.

N. B. Written consent of both husband and wife in case of married couples and written consent of single adult individuals or of parents or guardians of minors are contemplated in drafting the law.

Reference Committee Recommendation—Resolution regarding Sterilization by the Richmond County Medical Society was approved, with the deletion of the word "private" when referring to patients, with the recommendation that this be referred to the Legislation Committee for proper presentment to the Legislature.

House of Delegates Action—Recommended adoption of the Resolution on Sterilization with the qualifying recommendation made by the reference committee, which was moved, seconded and adopted.

Resolution on Standardized Insurance Forms

(Georgia Medical Society)

"It is recommended to the Medical Association of Georgia by the Georgia Medical Society that the Medical Association of Georgia pursue its program of influencing all insurance companies to use a standardized form relative to the medical information necessary for their purposes and that these forms fall into only three categories, that being liability, compensation and health."

Reference Committee Recommendation—The recommendation regarding standardized insurance forms was approved.

House of Delegates Action—Recommended adoption of the Resolution regarding Standardization of Insurance Forms as presented by the reference committee, which was moved, seconded and adopted.

REPORT OF REFERENCE COMMITTEE NO. 4

McClaren Johnson, Chairman

(The following reports as presented to this reference committee are printed in full with the reference committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 4 met at the Academy of Medicine at 8:30 a.m., May 14, 1956. Present were McClaren Johnson, Atlanta, chairman; Milford B. Hatcher, Macon, vice-chairman; William B. Quillian, Jr., Cartersville; Charles T. Cowart, LaGrange; C. L. Ayers, Toccoa; J. W. Yeomans, Jesup; Oscar Mims, Thomasville; George W. Wright, Augusta, secretary.

AMA Delegates

C. H. RICHARDSON, SR.

EUSTACE A. ALLEN

SPENCER A. KIRKLAND

The American Medical Association held two meetings in 1955, the annual summer meeting, which was held in Atlantic City, New Jersey, from June 6 to 10, and the mid-winter session which was held in Boston from November 29 to December 2.

The House of Delegates held sessions at both meetings which were attended by all three of the Delegates from Georgia, and at the Boston meeting all three received some recognition; two of whom were members of Reference Committees, and the other acted as chairman of one.

The major topics of discussion by the House of

Delegates at the Atlantic City meeting were Osteopathy, Medical Ethics, Medical Practices, Intern Training, Hospital Accreditation and Polio Vaccine.

The Osteopathic issue was related to the closer liaison between Osteopathy and Medicine.

The study of the relationship between Osteopathy and Medicine had been the subject of the work of a special committee for a number of years, and this committee offered both majority and minority reports at this meeting. The majority report stated they had reviewed the desire to elevate the standards of teaching in Colleges of Osteopathy. The committee recommended that Doctors of Medicine accept invitations to assist in Osteopathic under-graduate and post-graduate educational programs in those states in which this is not contrary to the announced policy of the state associations. This was in spite of the fact that the committee did not feel that the current education in Colleges of Osteopathy is free of the teaching of cultist healing.

The minority report stated that in its opinion an appreciable portion of current education in Colleges of Osteopathy definitely does constitute the teaching of cultist healing, and is an index that the osteopathic concept still persists in current osteopathic practice. For that reason they could not approve the recommendation that Doctors of Medicine teach in Osteopathic Colleges. However, they further stated that when the House of Delegates of the Osteopathic Association may voluntarily abandon the common so-called osteopathic concept, then the Trustees of the American Medical Association will be asked to appoint another committee for further discussion of the relations of Osteopathy and Medicine. The minority report was adopted.

Another matter to come before the House was in reference to a change in medical ethics, which had to do with the ownership of drug stores and dispensing of drugs and appliances by physicians. This matter was dealt with in Section VIII, Code of Ethics, which had stated that, "It is unethical for a physician to participate in the ownership of drug stores, unless adequate facilities are otherwise unavailable, and that this same principle applies to physicians who dispense drugs or appliances." This was changed to read, "That it is not unethical for a physician to prescribe or supply drugs, remedies or appliances as long as there is no exploitation of the patient." The committee emphasized that this section should be interpreted in line with Chapter I, Section VI, which reads: "The ethical physician engaged in the practice of Medicine, limits the sources of income received from professional activities to services rendered the patient."

The House then took under consideration the Internship approval programs, which were presented by the Reference Committee on Medical Education and Hospitals. The recommendations presented were: 1st: That a continuing study be made as to what should be the content of an Internship and what constitutes sound clinical experience during the Intern-

ship year. 2nd: That the one-fourth rule be adopted: "Any Internship program that in two successive years does not attain one-fourth of its stated complement be disapproved for internship training." It was pointed out to your Committee in hearings that data compiled for two years indicated that enforcement of this rule would have displaced only a few interns.

The same Reference Committee considered six resolutions on Hospital Accreditation, and their conclusions, which were presented in the following statement, and were adopted by the House, and we feel sure will be of much interest to the members of our Association. The statement is as follows: "The Reference Committee has reviewed all these resolutions, which in principle are similar, and apparently reflect a widespread dissatisfaction with the present functioning of the Joint Commission on the Accreditation of Hospitals.

"Therefore, your Reference Committee recommends that the Speaker of the House of Delegates be requested to appoint a special committee to review the functions of the Joint Commission of the Accreditation of Hospitals, to consist of seven members, none of whom shall be members of the Council on Medical Education and Hospitals or the Joint Commission on Accreditation of Hospitals.

"This special committee should be instructed to make an independent study or survey and report its findings and recommendations to the House at the next annual meeting in Chicago this summer. All physicians and hospitals were urged to pass on to this special committee any observations or suggestions concerning the functioning of the Joint Commission on the Accreditation of Hospitals."

The last matter of importance to come before this House of Delegates was in reference to "Salk Polio Vaccine," and the House passed three resolutions in reference to it, which were suggested by the Reference Committee on Hygiene, Public Health and Industrial Health. The first resolution reaffirmed the need for the presentation of reports on Medical Research before established scientific groups, and the publication of such reports, including methods employed, and data acquired on which the results and conclusions are based in recognized scientific publications.

The second resolution requests that the American Medical Association go on record as disapproving the purchase and distribution of the Salk Polio Vaccine by any agency of the Government, except for those unable to procure it for themselves, and that such necessary Federal funds be allocated to the proper State Agencies for such purpose. Also, that the American Medical Association urge the Congress of the United States to allow the Salk Polio Vaccine to be produced and administered in accordance with past procedures on any new drug or vaccine. The third resolution stated that the House of Delegates express profound gratitude to Dr. Salk, and its admiration for his monumental contribution to science.

The House of Delegates reaffirmed its previous recommendation that the United States withdraw from the International Labor Organization. It reaffirmed its opposition to the extension of the Doctor Draft Law, and recommended the creation of a Committee on Geriatrics, and warned against the danger embodied in state Legislative proposals designed to restrict the entire field of visual care to the profession of optometry.

At this meeting Dr. Dwight H. Murray, General Practitioner of Napa, California, was elected President, to begin his term of office at the June 1955 meeting in Chicago.

Dr. Millard D. Hall of Raleigh, North Carolina, was elected Vice-President, and Dr. George F. Lull was elected Secretary.

The House of Delegates voted the 1955 Distinguished Service Award of the American Medical Association to Dr. Donald G. Balfour, Surgeon and Author, of Rochester, Minnesota, for his outstanding contributions to Medicine and Humanity.

At the Interim meeting, which was held in Boston in November and December, the major subjects which came before the House of Delegates were Social Security, the report of the Committee on Medical Practices, Grievance Committees, and review of the Code of Medical Ethics.

Named as the General Practitioner of the Year was Dr. E. Roger Samuel of Mount Carmel, Pennsylvania, who was selected by a Special Committee of the Board of Trustees. This was announced at the opening session on Tuesday.

Major legislative policy action taken at the Boston meeting involved HR-7225, known as the Social Security Amendments of 1955. This bill was passed last summer by the United States House of Representatives, and is now pending in the Senate.

The objection of the American Medical Association to it is based upon the question of benefits to disabled persons at age fifty, upon certification of such disability by a physician. The American Medical Association felt that this would be an encroachment upon the American system of Medical Practice and would be detrimental to our patients and the American people, and further urged the creation of a well qualified commission to make an entirely objective and impartial study of the economic, social and political impact of Social Security, both medical and otherwise, and that the facts developed by such a study should be the sole basis for objective, non-political improvements to the Social Security Act.

In another action on another phase of Social Security in reference to the Old Age and Survivors Insurance Provisions of the Social Security Act, it was resolved that the House of Delegates of the American Medical Association recommend to State Societies that they poll their entire membership on this question, and that the results of the poll be transmitted to the Board of Trustees of the American Medical Association.

It was a decision on the part of this House to make

more realistic the position of the General Practitioner in both Medical Schools and Hospitals, and it was recommended that a continuing committee on Medical Practices be created in the American Medical Association, which committee shall consist of five members of the House appointed by the Speaker, three of whom shall be General Practitioners. It was further stated that this committee be directed to utilize all possible means to stimulate the formation of a Department of General Practice in each Medical School.

It was further recommended that the representatives of the American Medical Association on the Joint Commission on Accreditation of Hospitals be instructed to stimulate action by that body, leading to the warning of removal of accreditation of Community and General Hospitals which exclude or restrict hospital privileges for General Practitioners as a class.

The House approved the report of the Committee to recommend guides for Grievance or Mediation Committees, and recommended that the work of these committees be further stimulated, and that a uniform policy be adopted in which they are called frankly "Grievance Committees."

The final question of major importance was in reference to a proposed revision of the principles of medical ethics of the American Medical Association, and it was felt that there was need for widespread distribution of these principles, and careful study of the proposed changes before final action should be taken. It was recommended that these proposals be widely publicized by publishing them in the *Journal of the American Medical Association*, and also in state medical journals, and finally it was recommended that prior to the meeting in Chicago next June, the Council on Constitution and By-Laws and the Judicial Council meet in joint session to consider these proposed changes.

In passing on a few miscellaneous matters it was recommended that the Board of Trustees consider a dues increase for all Association members, with the increase designated for contribution to the American Medical Education funds.

Approval was given to the Committee of the American Medical Association to study the prevention of highway accidents. The Woman's Auxiliary of the American Medical Association was commended for its financial contributions in support of Medical Education, and approved was a recommendation by the Board of Trustees that the State Journal Advertising Bureau be separated from the American Medical Association and be given full autonomy.

The American Medical Association Board of Trustees announced that it again has appropriated \$100,000 to the American Medical Association Education fund for the support of medical schools. The California Medical Association made a similar bequest of \$25,000 and the Utah State Medical Association announced an \$11,000 contribution.

At the opening session, Dr. Elmer Hess, AMA President, told the House that complacency should be regarded as the Medical Profession's greatest enemy. He said educational efforts must be intensified, and the list of physicians' tangible accomplishments for the health benefit of the public must be increased.

Reference Committee Recommendation—AMA Delegates Report approved.

House of Delegates Action—Recommended adoption of the AMA Delegates Report as presented by the reference committee, which was moved, seconded and adopted.

ADDENDUM

Osteopathy

DAVID HENRY POER, *Secretary*

It appears evident that many osteopaths in Georgia are at present practicing "M.D. type" medicine which includes the writing of prescriptions, obstetrical deliveries, and the performance of surgical operations. It is a fact that at the present time there are eight (8) osteopathic hospitals licensed in Georgia, and the number is increasing.

In general these osteopathic practitioners have moved into communities where no M. D. physicians were available. It appears that in these areas they are doing a general type of work of an acceptable grade. It has been reported that some allopathic physicians are working with them in private hospitals, and it is believed that their patients are receiving acceptable medical care.

It is recommended that the American Medical Association continue its efforts to encourage all schools of osteopathy to discard their "cultist theories" and become Grade A regular schools of M.D. medicine. This would seem to be the most desirable solution to this problem of patient care rendered in Georgia, and our AMA delegates should be so instructed.

Reference Committee Recommendation—The addendum report to the AMA Delegates Report concerning Osteopathy was accepted as information.

House of Delegates Action—Recommended the adoption of the recommended action in accepting the AMA Delegates addendum report concerning Osteopathy for information, which was moved, seconded and adopted.

First District Councilor

LEE HOWARD, SR.

Your Councilor has attended every meeting of the Council during the year, including several special meetings, also two Committee meetings in connection with the newly formed Hospital Committee.

The Vice-Councilor has been most helpful, especially in affording transportation and company for the Thomasville meeting.

There has been some progress towards consolidation of small societies in the District into larger groups, as outlined in my last report. The Southeast Georgia Society is listed as of December 31, 1955, with 14 members, a gain of one member during the year. It is my understanding that Tattnall County has recently joined in with Toombs and Montgomery Counties, bringing the Southeast Georgia Society

membership up to 21, which is now large enough to be a very active society.

It is my feeling that the Liberty-Long-McIntosh Society should be deleted as its two members cannot function as a society, according to present requirements.

It is still planned to bring Burke, Jenkins and Screven Counties, with a present membership of 19, into one society which would complete the project to have four major societies in the District, if Emanuel County joins in.

There has been very little change in membership as of December 31, 1955, an overall gain of two members. The major shift was in Emanuel County Society, with a loss of three members. No other society gained or lost more than one member.

The Georgia Medical Society, Chatham County, has 136 members out of the 204 members of the District.

There is a need for stimulating attendance, interest and objectives in the individual societies of the District and this could well be a major project for the ensuing year.

FIRST DISTRICT MEMBERSHIP

Counties	Members December 31, 1955		Members December 31, 1954	
	MAG	AMA	MAG	AMA
Bulloch-Candler-Evans . . .	21	17	20	15
Burke	10	7	9	8
Emanuel	5	5	8	5
Georgia Medical Society .	136	122	135	118
Jenkins	3	3	3	3
Screven	6	6	5	5
Southeast Georgia	14	12	13	12
Tattnall	7	3	7	3
Liberty-Long-McIntosh . .	2	2	2	2
TOTAL	204	177	202	171

First District Vice-Councilor

CHARLES T. BROWN

All members of the Medical Association of Georgia are elated over passage of the Naturopath Bill. This we feel represents a forward step in better medical care for the people of the State. The threat of chiropractors is resented by many of our members. One of the most enjoyable events of the entire year was experienced by members of the Council and their wives at the meeting in Thomasville. Dr. George Dillinger and members of the Thomas County Medical Society are to be congratulated for their wonderful hospitality and good time had by all. It is a source of great satisfaction to see the renewed interest in the annual meeting of the First District Medical Society in Statesboro.

Your Vice-Councilor has attended all meetings of the Council with the exception of one, and has tried to assist the Councilor to the best of his ability when called upon.

Reference Committee Recommendation—The report of the First District Councilor was accepted and approved.

House of Delegates Action—Recommended adoption of the First District Councilor Report as presented by the reference committee, which was moved, seconded and adopted.

ADDENDUM
Liberty-Long-McIntosh
DAVID HENRY POER, Secretary

It is recommended that the House of Delegates instruct the Council to withdraw the charter from Liberty-Long-McIntosh County Medical Society as a component society of the Medical Association of Georgia as the so named society has ceased to function, and it is further recommended that the two (2) physician members of this society be directed to join the adjacent societies in the jurisdiction of their practice.

Reference Committee Recommendation—The reference committee accepted and approved the addendum report concerning Liberty-Long-McIntosh County Medical Society.

House of Delegates Action—Recommended adoption of the addendum report to the First District Councilor's Report concerning Liberty-Long-McIntosh County Medical Society as presented by the reference committee, which was moved, seconded and adopted.

Sixth District Councilor

HENRY H. TIFT

The winter meeting of the Sixth District Medical Society was held in Macon on November 30, 1955. A fine program was presented, with Dr. Lowery Davenport and Dr. Waddell Barnes as local speakers and Dr. Arthur J. Merrill as guest speaker.

The officers for this society are Dr. John Bell, Dublin, President; Dr. Walter Bramblett, Forsyth, Vice-President; and Dr. Herbert N. Olnick, Macon, Secretary.

The spring meeting was held in Dublin on April 11, 1956, with members of the Laurens County Medical Society as host. Principal speaker was Dr. Peter L. Scardino of Savannah.

I have attended most of the meetings of Council and have actively supported, by correspondence and personal contacts, the legislative program of the Medical Association of Georgia.

SIXTH DISTRICT MEMBERSHIP

Counties	Members December 31, 1955		Members December 31, 1954	
	MAG	AMA	MAG	AMA
Baldwin	28	12	26	11
Bibb	155	140	141	124
Jasper	4	3	4	3
Jefferson	7	4	6	4
Laurens	36	10	23	10
Washington	13	10	13	11
TOTAL	243	179	219	163

Reference Committee Recommendation—Sixth District Councilor's Report was accepted and approved.

House of Delegate's Action—Recommended adoption of the Sixth District Councilor's Report as presented by the reference committee, which was moved, seconded and adopted.

Professional Conduct Committee

A. M. PHILLIPS, *Chairman*

As Chairman of the Professional Conduct Committee of the Medical Association of Georgia, I am happy to report to the Association that there have been no problems presented to your Committee for consideration during the year. If such problems have arisen, they were handled by local committees. It has

not been necessary to call a meeting of the State Committee.

Reference Committee Recommendation—Professional Conduct Committee Report was accepted, and we wish to commend MAG members for having made possible this good report.

House of Delegates Action—Recommended adoption of the Professional Conduct Committee Report as presented by the reference committee, which was moved, seconded and adopted.

Awards Committee

TED F. LEIGH, *Chairman*

The present membership of the Committee on Awards of the Medical Association of Georgia consists of Dr. Hoke Wammock, Augusta; Dr. Charles H. Wasden, Macon; Dr. Mark S. Dougherty, Atlanta, and myself.

The primary efforts of our committee during this fiscal year have been directed toward making the scientific exhibits for the annual meeting here in Atlanta an outstanding feature of the convention.

In cooperation with the Secretary of the Medical Association of Georgia, a floor plan for the Scientific Exhibit Section in the Exhibit Hall of the Atlanta Biltmore Hotel was devised. The exhibit area consists of thirty-one 4x8 foot sections.

Reference Committee Recommendation—The Report of the Awards Committee was accepted and approved.

House of Delegates Action—Recommended adoption of the Report of the Awards Committee as presented by the reference committee, which was moved, seconded and adopted.

Better Health Council

MRS. BRUCE SCHAEFER, *President*

The annual meeting of the Board of Directors of the Better Health Council of Georgia was held October 18, 1956. Two new members were elected to the Board. The membership committee reported a membership of 53 contributing and participating organizations, along with individual memberships.

The Council has operated with limited staff and finances for the past year. However, plans have materialized whereby funds are available for employing a full-time executive director.

In the absence of an executive director, the President has had to give a great deal of time to the Council's program and has represented the Council at many local health meetings and at national meetings such as the National Health Forum which was sponsored by the National Health Council in New York City, March 1955, where she served as a group leader in the discussion "Putting Tools to Use for Effective Community Action" relative to *Health Careers Guidebook*. The *Guidebook* points up 156 careers in the field of health and has been sent to every high school and junior college in the United States. Its purpose is to give young people a new and clearer view of career opportunities throughout the field of health—and thereby influence them to take health careers into account in planning their own futures. This is the most comprehensive guide to careers in the health field that has been published. It is interesting to know that The Equitable Life Assurance So-

ciety of the U. S. made possible this nation-wide service to health.

The Better Health Council is working closely with the National Health Council on the follow-up of this project in Georgia by contacting health councils and suggesting that they cooperate with school officials and counselors in getting health career information before the students. Reports show that the *Guidebook* is being used very effectively in the high schools throughout Georgia. Many schools have planned a CAREER DAY.

As President of the Council, Mrs. Schaefer is a member of the Planning Committee for the 1956 Health Forum on "Chronic Illness" which will be held in New York City, March 21-23, 1956. Preceding the Health Forum, on March 19 and 20, she will participate with 19 other people from over the United States in a consultation series on State and Local Health Councils.

The Better Health Council was represented at the first planning meeting of the State Health Department on the polio vaccine shots and cooperated by writing letters to health councils in the state and to communities where interest in health councils had been indicated, giving advance information about the polio shots and suggesting that local communities take advantage of this opportunity to band together the voluntary and official health agencies to achieve a unified task. One community organized a health council as a result of these efforts.

General information about health councils was sent to 12 different counties in the state—three of these counties have formed health councils (the percentage would have been higher had we been able to send a representative into the community as was requested); information about health councils was also sent to four out-of-state cities.

The Better Health Council is aware that the urgent need is getting to the grass roots level with the proper health information and guidance for solving problems and evaluating health needs. And how can this be better accomplished than by organizing health councils?

Through our sponsorship of regional health conferences, we have on file the names of hundreds of Georgia citizens who are interested in all phases of health, and through this medium we have been able to render assistance to several organizations in increasing attendance at their meetings: the Woman's Division of the State Department of Civil Defense held four area workshops last year, and the Council wrote letters of invitation to approximately 200 people in these areas; the Council cooperated with the Division of General Extension, University of Georgia, by furnishing names of interested people to be invited to the Conference on Leadership in School Health Education. (At this conference in Athens we had the privilege of displaying an attractive exhibit of health materials of our member agencies.)

Ten tape recordings on different facets of health which were promoted by the Council, have been broadcast on several local radio stations in the state.

Another important part of our program is the co-operation between the Better Health Council and the Rural Health Committee of The Medical Association of Georgia. Last year we made surveys of nine rural communities which had requested placement of doctors. When the facts were gathered as to whether or not the locality needed a doctor and was able and willing to provide certain facilities, etc., the information was given to the Chairman of the Rural Health Committee, and the approved localities were published in the *Journal of the Medical Association of Georgia*.

The Council is represented on the State Medical Education Board which furnishes scholarships to medical students for their education and places doctors in small communities.

Since we are listed in the classified section of the telephone directory, we receive daily inquiries for all sorts of health information. Many times we are able to do a good public relations service by directing inquiries to the proper health department or agency.

Future Program. With added staff personnel, we will work actively to have a continuous cycle of regional health conferences and more intensive personal contact with lay groups and health councils in the state; to cooperate with the *Health Careers* project; to cooperate with the Rural Health Committee of the Medical Association of Georgia on Physician Placements and other mutual interest programs; to cooperate with the Governor's Committee and the Board of Regents in placing in small communities doctors who have received scholarships for their medical education through the State Medical Education Board; to support appropriate health bills in the General Assembly; and to issue *Newsletter* quarterly.

The Better Health Council is guided in purpose and program by the leadership provided by the Medical Association of Georgia. We greatly appreciate the confidence and support of the Association and believe along with the American Medical Association that "the most effective means to stimulate cooperative effort between the medical profession and other citizens' groups is THE COMMUNITY HEALTH COUNCIL."

Reference Committee Recommendation—The Better Health Council Report was accepted and approved with commendation and thanks from the medical profession for the volume and quality of work done by this council.

House of Delegates Action—Recommended adoption of the Better Health Council Report as presented by reference committee No. 4, which was moved, seconded and adopted.

ADDENDUM

Mr. Chairman, members of the House of Delegates, ladies and gentlemen: To the Medical Association of Georgia convention here assembled, I bring greetings and best wishes from the other 52 health and health-related agencies making up the membership of the Better Health Council of Georgia.

The Better Health Council announces with pleasure the expansion of its program projects through the employment of a full-time Executive Director as of April 1 passed.

Resulting from the meetings of the Executive Committee of the Medical Association of Georgia and the Better Health Council, there has come about an amalgamation of efforts relating to the Rural Health program in the State of Georgia (this is referred to in your headquarters report handbook, page 25).

The Council President and Executive Director attended a two-day consultation on state and local health councils on March 26-27 in New York City—sponsored by the National Health Council. Representatives from 20 states participated.

The Council president served on the planning committee of the 1956 National Health Forum on Chronic Illness.

The Council will conduct on May 19 in Augusta and Atlanta one day programs for junior and senior medical students, their wives and fiancées—the purpose being to encourage the field of general practice.

As a result of letter writing, conferences, etc., the Nemours Foundation of the du Pont family will finance annual Georgia conferences on crippled children. The Council is sponsoring and directing the first conference with the assistance of sixteen state organizations and Dr. A. R. Shands, Jr. of the Alfred I. du Pont Institute. This conference will be held in late November of this year.

May I again invite your attention to the Better Health Council complete report on page 95 of the House of Delegates Handbook. I thank you.

Reference Committee Recommendation—The Better Health Council Addendum was accepted and approved again with commendation.

House of Delegates Action—Recommended adoption of the Better Health Council Addendum as presented by the reference committee, which was moved, seconded and adopted.

Insurance Board

DAVID R. THOMAS, JR., *Chairman*

The work of your Insurance Board during the past year has been much less hectic than in 1954-55. We have been able to consummate much that has been done during the past years and a meeting is scheduled to be held in Atlanta, Georgia, on April 15, 1956, and a supplementary report will therefore be necessary.

Our accomplishments could not have been attained without the support and hard work of the members of the Board as well as Mr. Dunaway, Mr. Krueger and Mr. Kiser. The cooperation and support of all is deeply appreciated.

Dr. John Elliott of Savannah has continued to handle the unlisted procedures for the insurance claims as well as those unusual claims. He has handled this admirably and has been unstinting of his time and interest, making it possible for this Board to perform one of its valuable functions.

Professional Liability: After much work done by the sub-committee on professional liability insurance and the approval of the entire board, the Saint Paul Mer-

cury Indemnity Company was approved to handle group malpractice insurance for the Medical Association of Georgia.

Representatives from the insurance committees of each component society were invited to meet with us in Atlanta in September 1955. At that time representatives from the Saint Paul Mercury Indemnity Company met with us and the program was explained. Subsequently Mr. Krueger and Mr. Kiser have gone through the State explaining the program to each society and your Board feels that the support that you have given us is very gratifying. More than 750 policies are now in force by members of the Medical Association of Georgia. We have been assured that a reduction in premium will be made and this will be presented to you in May.

Group Life Insurance: The group life insurance of the Medical Association of Georgia was underwritten by the Provident Life and Accident Insurance Company and became effective October 15, 1954. Since that time over \$60,000 has been paid to the estates of deceased policy holders, which we feel has been very worthwhile.

Group Health and Accident Insurance: Since the inception of our group health and accident insurance program in 1951, over \$200,000 has been paid to the members of the Medical Association of Georgia in claims. The Board feels that this has been a very good investment for the members of the Medical Association of Georgia and offers them needed and added protection for loss due to accident and illness. *The Georgia Plan:* The Georgia Plan is being completely revised and you will have a report on this at the time of the meeting. An addendum to this report will of necessity have to be submitted.

ADDENDUM

A final meeting of the Insurance Board was held at the Bon Air Hotel, Augusta, Georgia, Sunday, April 29, 1956, at which time the work of the year was consummated. In addition to the members of the Insurance Board, representatives of the Health Insurance Council were also present. These men have cooperated in an advisory capacity. Their cooperation and advice have been of great assistance and is deeply appreciated.

Professional Liability Insurance: The St. Paul Mercury and Indemnity Company has advised the board that they are proposing a 10% reduction in rates, effective June 1, 1956. The company will be asked to review their experience again prior to March 1, 1957, in order that we might give you a full report at the Annual Session in 1957. We have reason to believe that St. Paul Mercury is cooperating with us and will offer as much reduction in rates as their experience will allow.

Standardization of Insurance Forms: The standardization of insurance forms has been studied, and in cooperation with the Health Insurance Council simplified forms are being presented that the board feels will enable the insurance companies to have

pertinent information and eliminate much of the present burden that is being placed upon the practicing physicians. We realize that we, as physicians, have a responsibility to our patients and the insurance companies, and it is the considered opinion of the board that simplification of insurance forms is necessary. It is hoped that this study can be completed and standard forms adopted with the cooperation and approval of insurance companies during the coming year.

An introduction card for insurance companies who are handling MAG approved insurance was adopted in order that any representatives of the approved companies handling our insurance would be introduced to you giving "the name of the representative, the name of the company and the type of insurance that he is presenting"; in order that you might know who you are granting an interview to and that the matter at hand has the approval of your Insurance Board. Should there be any abuse of this, it is the desire of the board that the Executive Secretary be advised, citing the incidence. It is hoped that this will help both you and the insurance companies.

The Georgia Plan: The Georgia Plan was received, and a new *Blue Book* and a schedule of surgical and obstetrical benefits and optional medical and optional anesthesia benefits was approved by the Board and by the Health Insurance Council. This work as approved should be cleared by the insurance companies and become effective in July 1956. It was agreed by the board that the insurance now in force would be accepted at that value for the duration of the policies now in force, but under no circumstances to extend beyond 18 months. It is the opinion of the board that it will take this length of time to have all the insurance rewritten and that after that time the entire new schedule of fees will be full in effect.

MAG Endorsed Insurance Plans: Reappraisal of all MAG approved insurance programs for members of the Association, with careful consideration of bringing these plans up-to-date, is to be done annually. This is necessary with changing economic conditions, and each member is advised to reappraise his personal programs.

Reference Committee Recommendation—The Insurance Board Report was accepted and approved. Reference Committee No. 4 wishes to commend David R. Thomas and his committee for their untiring efforts.

House of Delegates Action—Recommended adoption of the Report of the Insurance Board as presented by the reference committee, which was moved, seconded and adopted.

Resolution on Standardization of Insurance Forms

ROBERT H. VAUGHAN

(For Muscogee County Medical Society)

WHEREAS, insurance companies in Georgia submit varied and lengthy forms relative to medical information necessary for their purpose; and,

WHEREAS, the forms fall into three broad categories, namely; liability, compensation and health; and,

WHEREAS, it is inconceivable that any one in-

surance company should need more information relative to a disorder of health than another insurance company when both cover the same type disorders; and,

WHEREAS, a physician would more quickly fill out a familiar standardized form thus saving the physician time and thus saving the insurance company time

THEREFORE, BE IT RESOLVED, that the House of Delegates of the Medical Association of Georgia request that insurance companies in Georgia writing insurance in these fields standardize their forms to be simplified so as to be mutually satisfactory to the physicians and the insurance industry, and

BE IT FURTHER RESOLVED, that the Insurance Board of the Association be requested to carry out the intent of this resolution with the power to act in influencing the Georgia insurance companies in this field to satisfactorily standardize their forms.

Reference Committee Recommendation—The Resolution on the Standardization of Insurance Forms as submitted by the Muscogee County Medical Society was approved.

House of Delegates Action—Recommended adoption of the Resolution on the Standardization of Insurance Forms as presented by the reference committee, which was moved, seconded and adopted.

Blood Banks Committee

WARREN B. MATTHEWS, *Chairman*

We planned two activities for the year. One was to compile and adopt a "Minimal Standards for Blood Banks"; the other activity planned was the organization of a Blood Bank Association of Georgia. Both of these projects have been accomplished.

The "Minimal Standard for Blood Banks" will be submitted to the House of Delegates of the MAG for approval in May 1956. The Blood Bank Association of Georgia was founded on September 17, 1955, at a meeting in the Macon Hospital. Such an organization was considered advisable in order to coordinate the efforts of many people interested in blood banking. Another purpose was to formulate rules for blood collection and preservation, so that blood might be shipped safely from place to place, in case of emergency. The organization of such an association was also recommended by Civil Defense authorities. At the organizational meeting the following officers were elected: President, Dr. Edward V. Hastings, Augusta, Georgia; Vice-President, Dr. L. H. Campbell, Macon, Georgia; Secretary, Dr. Walter Sheppard, Augusta, Georgia. This organization includes not only physicians but nurses, hospital administrators, technologists, and others, who have a legitimate interest in blood banking. The Constitution and By-Laws for the organization are being formulated. It is contemplated that the organization will work in close coordination with the Medical Association of Georgia.

We request that the House of Delegates consider and, if possible, approve our "Minimal Standards for Blood Banks." We realize that these standards will be subject to constant revision as time goes on.

Reference Committee Recommendation—Reference Committee No. 4 accepts the Blood Banks Committee Report as information. We feel that we cannot approve this report without assurance that the Blood Banks Association of Georgia will have adequate supervisory control by the Medical Association of Georgia, and that approval should be withheld until the Constitution and By-Laws of the Blood Banks Association have been completed and submitted for approval.

House of Delegates Action—Recommended that the Blood Banks Committee Report be accepted and that the reference committee recommendation regarding this report be approved as presented by the reference committee, which was moved, seconded and adopted.

ADDENDUM

Minimum Standards for Blood Banks

Organization: A blood bank must be supervised by either:

1. Medical staff: must have an organized blood bank committee composed of members of the medical staff of the hospital.

2. A pathologist who is a resident member of the medical staff of a hospital.

3. In the case of a blood bank that is not operated by a hospital, it must be under the professional direction of a qualified doctor of medicine.

Among the duties of the director of a blood bank will be the following:

a. Immediate supervision of blood bank personnel regarding any medical and technical problems involving medical judgement.

b. Having knowledge of the fundamental scientific facts upon which the blood bank techniques rest.

c. Selection of technical procedures that will be performed by technical personnel. Determine which will be "routine" procedures done on blood donor and recipient.

d. To assure the availability of a physician to be either on call or present at all times for consultation.

Technical Personnel:

1. Must be properly trained in the techniques employed and the fundamental scientific facts upon which the techniques rest.

2. Will maintain accurate and complete records of work done in the blood bank.

3. Perform all technical procedures relative to the collection and processing of blood for administration.

4. Exercise necessary precautions to safeguard both donor and recipient of blood.

5. Perform only those tests which have been approved by the director of the laboratory.

6. Perform only those tests requested by a doctor of medicine.

7. To regard all records as medical records and make them available only to qualified persons.

Donor Selection

The person who presents himself to a blood bank as a potential donor of whole blood must be carefully screened not only to prevent transmission of disease through use of whole blood, but to protect the donors' health and welfare. The following requirements and recommendations for meeting these requirements are in accord with current medical practice. It is not possible to cover all questions that arise

in donor selection, therefore a physician should be readily available to exercise medical judgement in individual cases.

General Requirements

1. **Facilities:** Surrounding which are conducive to a truthful and confidential medical history must be provided. Phlebotomy may be performed in a suitable place where the donor may rest a few minutes after giving blood.

2. **Records:** A permanent file of Donor Registration Cards must be in the blood bank. This donor record is a medical record and only qualified personnel may have access to it. It must contain the following information which the donor must give each time he presents himself for donation of blood.

A. General Information:

Full name (including middle initial) sex, marital status, address, telephone number, place of employment and age. Donors under 21 and over 60 must not be accepted except in the case of the former:

1. Signed consent is given by parent or legal guardian.

2. Members of armed forces who are over 17 years of age.

3. Individuals who are married and are over 17 years of age.

The legal age of majority in Georgia is 21 years of age.

Date of present donation

Date of last donation

NOTE: There must be an interval of not less than 6 weeks between donations of 500 ml. of blood.

4. Release for donor:

It is recommended that each donor should sign a release before the blood is withdrawn. A suggested form which may be used is:

"I, the undersigned, am voluntarily depositing my blood with the (name of Blood Bank), hereby agreeing that it may use such blood, or any part thereof, in any way it deems advisable, and that credit will be given to the individual or organization designated by me in writing in the registry unless tests made after withdrawal reveal conditions rendering such blood unsafe for transfusion. I understand that the tests, examinations and procedures used by the (name of Blood Bank), in the collection of blood are recognized as safe and I therefore release the (name of Blood Bank), and the doctors, technicians, nurses, agents and officers connected therewith from any and all untoward reactions resulting therefrom."

B. Blood Groups and RH factor of Donor:

NOTE: Preliminary blood group may be performed as a "screening test" using Anti-A and Anti-B high titre serums on the donor card. This provides a permanent record of the test, reducing the possibility of clerical error in recording blood group.

This preliminary blood group must be checked by another method.

Weight—Donors who weigh more than 110 lb. may give a full 500 ml. of blood.

Temperature—Oral temperature of 99.6° disqualifies donor. Temperature is taken with a suitable thermometer held in closed mouth at least 2 minutes.

Blood Pressure—Must be greater than 100/50 and less than 200/110 when taken with an acceptable sphygmomanometer. Any abnormalities must be referred to a physician for interpretation.

Pulse—Rate of less than 60 or more than 100 per minute or any irregularity of rhythm should be referred to physician.

Hemoglobin—Must be above 12.5 grams for females and 13.5 gms. for males as determined by usual clinical methods, or if the Copper sulfate method is used the

specific gravity must be above 1.053 for testing females and 1.055 for males.

C. Medical History

It is recognized that a complete physical examination is neither feasible nor adequate to assure freedom from transmissible disease in the donor, or to protect the donor from harm from the donation of 500 ml. of blood. Therefore the donor must supply proper answers to questions about the following specific conditions which help determine the suitability of a donor.

1. Malaria—No donor may be accepted who has had clinical symptoms of malaria or who has taken atabrine, or quinine or other suppressive drugs within two years.

NOTE: In view of the fact that malaria is occasionally transmitted after long symptom free periods, there is no absolute safe guard against the transmission of the disease.

2. Syphilis—All donors giving a definite history of syphilis are disqualified unless they produce evidence that they have been adequately treated and are serologically negative at the time of presentation for donation.

NOTE: Blood collected from persons who have had syphilis, adequately treated and serologically negative must be clearly marked. Such blood must not be issued from the blood bank unless stored for over 96 hours in the refrigerator.

3. Jaundice: All donors with a definite history of infectious or hemologous serum hepatitis must be rejected. Donors who have had intimate contact with persons suffering from acute hepatitis should not be accepted for six months after last contact.

4. Tuberculosis—All donors who have had definite active clinical tuberculosis are disqualified.

5. Brucellosis—A history of infection with brucella within two years disqualifies a donor.

6. Illness within the last month—Persons who have a history of colds, fever, grippe (flu) persistent cough, sore throat, pain in chest or other manifestations of upper respiratory infection must be rejected until at least one week after all active symptoms have subsided. Questionable cases must be referred to the physician.

7. Recipient of blood or plasma transfusions—If either blood or plasma has been received within six months the donor must be rejected.

8. Weight loss—Recent weight loss of 10 lbs. or more disqualifies a donor, unless individual has been on a reducing diet.

9. Convulsions—A history of seizures or convulsions (except in infancy) excludes the donor.

10. Bleeding abnormalities—Abnormal or excessive bleeding for any reason is cause for rejection.

11. Pregnancy—During pregnancy and for 12 months post partum a donor should be excluded, unless on decision of the physician.

12. Surgery—Major surgical operations within 6 months excludes donor.

13. Dental extractions: Tooth extraction within one week is cause for rejection.

14. Alcoholism—Persons obviously under influence of alcohol are not acceptable.

15. Diabetes—Persons requiring insulin for treatment of disease are disqualified.

16. Drug addiction—Drug addiction or any history of addiction excludes donor.

17. Immunizations—

a. Rabies—Donor may be accepted one year after last immunization.

b. Smallpox—Acceptable 2 weeks after immune reaction or scab comes off.

c. Yellow fever—Acceptable 2 weeks after last injection.

d. Typhoid, typhus, rocky mountain spotted fever, influenza, cholera, diphtheria and tetanus—Acceptable 1 week after last injection.

e. Vitamin, hormone, liver and other injections: Must be evaluated by physician.

18. The extent of the following conditions usually disqualifies prospective donors, but the final decision must be made by the physician.

Rheumatic fever

Kidney disease

Cardiovascular disease

Skin diseases

D. Nourishment—

It is preferable to encourage donors to eat non-fatty meals rather than enforce a starvation period. Too long a period of strict fasting lowers the blood sugar and increases the donor reaction rate.

The above guide cannot cover all questions that arise in donor selections. That is one of the reasons why a physician should be present or quickly available at every blood collection to exercise medical judgment in individual cases.

Collection of Blood from Donor

1. Facilities for collection of blood must be in an area where the donor may rest on a reasonably comfortable cot or table during the donation of blood, and for 10-15 minutes after donation.
2. Equipment for venipuncture includes the following:

a. Blood Collection Bottle:

The original bleeding bottle must be the final container and must meet NIH minimum standards. It must maintain a contamination proof seal until the contents are used. It should be precooled to 4 to 10° C whenever prior to the collection of blood. Bottle must be inverted so that blood enters through the ACD solution.

Anticoagulant Solutions:

When blood is to be collected for use as whole blood, the bottle contains 120 ml. of ACD* solution (NIH formula B).

The bottle must be pyrogen-free and disposable.

*Minimum requirements: Citrated whole blood, human National Institutes of Health, solution B:

Tri-sodium citrate	13.2 gms.
Citric Acid	4.8 gms.
Dextrose	14.7 gms.
Water	1000 ml.

b. Blood Collection Set: Must be a disposable set which meets NIH minimum requirements. It must be sterile and pyrogen free.

c. Clamps or hemostats for tubing.

d. Pilot tubes and labels.

e. Sponges

Adhesive tape

Bandage scissors

Tourniquet

3. Identification: Blood Bottles and Pilot Tubes Must be properly identified with the donor.

1. A system which follows from donor to recipient must be used to identify the blood. Numbers and names must be closely checked. Errors may be fatal.

2. One sterile pilot tube must be firmly attached to the bottle before phlebotomy is done and must not be detached until after blood has been cross matched and selected for transfusion to a particular recipient. Additional tubes for laboratory testing should also be collected. Pilot tubes must be identified in the same manner as the bottle.

4. Sterilization of Instruments:

1. Apparatus or instruments such as syringes, needles and lancets or other blood letting devices capable of transmitting infection from one person to another must be heat sterilized prior to use for each donor. Separate needles and syringes must be used for each donor. Heat sterilization must be by autoclaving for 30 minutes at 121.5° C (15 lb. pressure), by dry heat for 2 hours at 170° C, or by boiling in water 30 minutes.

5. *Preparation of Venipuncture site:* The preparation of the skin at the site of venipuncture shall be adequate to protect the donor against infection. The following procedure is considered satisfactory:

1. Cleansing the skin:

- a. Using an acceptable liquid soap or detergent, the skin is rubbed vigorously.
- b. Remove the dissolved dirt and fat with alcohol 70%, or a solution of 10% acetone in 70% alcohol.

2. Preparing the arm:

- a. Treat the cleansed area with iodine (3% tincture of 2% aqueous) using a sterile applicator. Tincture of merthiolate 1/1000 may be substituted.

3. After iodine or other agent has dried it is removed with 70% alcohol.

4. Sterile sponge must be left over site until the needle is ready to insert into the vein. Avoid touching the prepared venipuncture site for exploration until after the needle has been inserted beneath the skin.

6. *Rate of Blood Withdrawal:* A steady slow rate of blood withdrawal not to exceed 100 cc. per minute is essential in keeping the incidence of reactions low. Adequate rest following donation is also necessary.

7. *Reactions of Blood Donor:* Although the withdrawal of blood is usually accomplished with no perceptible reaction, a small percentage (4 to 6%) of donors show some systemic reaction, before, during or following venipuncture. It is much better to prevent a reaction than to treat one. Personnel who work with blood donors must be vigilant in observing, forestalling and recording donor reactions.

Phlebotomy must be discontinued at the first sign of donor reaction and a physician should be called. Ammonia inhalants may be used, but no drugs may be administered without a doctor's orders.

8. *Storage of Blood:* Immediately after bleeding, the blood must be placed in refrigerated storage at a constant temperature of 4 to 6° C.—not to exceed 4 to 10° C. Blood must not be allowed to freeze.

The unit used for refrigeration of blood must contain a thermometer at all times. A record of reading on this thermometer must be made not less than three times daily. This record of refrigerator temperature must be kept on file in the blood bank.

It is recommended that the refrigeration unit be equipped with a fan to circulate the air inside, have an adequate alarm system, and a device for making a permanent continuous record of the temperature within. Any institution holding blood over 24 hours should have a refrigerator used exclusively for the storage of blood.

9. *Shipping of Blood:* All blood for shipment should be thoroughly pre-cooled to a temperature of 4-10°, and packed, with pilot tubes affixed, in containers which have been pre-cooled to the same temperature. The containers should be sent with full cans of chopped or cracked ice. Dry ice should NOT be used. All boxes should be clearly marked in large size type to indicate, "THIS SIDE UP, HUMAN BLOOD, HANDLE WITH CARE, DO NOT ALLOW TO FREEZE, OR TO BECOME OVERHEATED, RUSH, DELIVER IMMEDIATELY UPON ARRIVAL DAY OR NIGHT." The insulated box for shipping blood must be

one that keeps the ice separated from the blood, one in which only cracked ice is used.

The name and address of the blood bank should be clearly shown on the boxes.

It is recommended that blood to be shipped be as fresh as is possible, not to exceed the age of one week.

Blood should not be released more than one hour prior to departure, and should not be left standing for a considerable period of time.

All boxes of blood released for shipping should be sealed. This seal should not be broken unless it is evident that more than 24 hours is to elapse in the shipping. In such a case, the seal may be broken, the ice compartment filled, and a record made of the circumstances and the time of breaking of the seal.

Blood boxes should never be exposed to extreme temperatures.

NOTE: *An NIH license must be held by banks engaging in interstate shipment of blood.*

10. *Labels for Blood:* Whole blood and re-suspended red blood cells must be properly labeled. The label must provide the following information:

1. In a most prominent position and print, the proper name Citrated Whole Blood (Human), or Resuspended Red Blood Cells (Human).

2. In a lesser print but following the proper name of the contents of the bottle, it should state that it contains the indicated amount of human blood plus the amount of anticoagulant solution contained in the bottle.

3. That it is serologically negative, specifying the type of tests.

4. That label shall also contain a warning in bold type as follows:

"Caution—keep continuously at 4-10° C."

5. It shall provide the donor's name or number of bottle.

6. It shall show the expiration date and if desired, the date of withdrawal of blood.

7. It shall provide the blood group and Rh type of the donor stating that he is Rh-negative, the latter to be accompanied by information concerning test serums used to determine the negativity—for example, "rh-negative (cde)" or "when tested for Rho (D), rh' (C) and rh' (E)."

8. The label shall also contain the following warnings:

- a. Crossmatch before using.
- b. Administer without warming.
- c. A filter must be used in the administration.
- d. Mix thoroughly immediately before using.
- e. Do not add other medication to the bottle of blood prior to administration.

9. The label shall clearly show in bold type and in a prominent position the name and address of the laboratory collecting the unit of blood.

10. Label must be provided for the recipient and fixed to the bottle. This shall show the name of the hospital, patient's name, chart number, room number, patient's blood group, Rh type, date of crossmatch and initials of technician responsible for crossmatch.

The use of colors to designate the various blood groups while not mandatory, should be either in black and white or according to the following scheme. This is in accordance with requirements of the National Institutes of Health.

Blood group A—Yellow
Blood group B—Pink

Blood group C—Blue
Blood group AB—White

Processing of Blood

1. *Determination of the blood group:* Each bottle of citrated whole blood must be classified as to blood group on the basis of tests done on pilot tube samples and the findings must be made a part of the laboratory record and of the final container label. Each blood should be tested independently for its group by two workers, or by the same worker using either or both of the following methods. A grouping procedure which minimizes errors and assures accuracy is a single grouping of the donor's red cells against satisfactory grouping serums, followed by a second grouping test which uses the donor's serum against fresh A and B cells. A second procedure capable of giving accurate results is to determine the grouping of the donor's cells independently against two satisfactory sets of grouping serums of different lot numbers. The results of the tests must be recorded on the bottle label and on the donor's history card. This requirement applies to all donors regardless of any previous donation as the record refers to the blood in a particular bottle rather than to a donor. A bleeding is not satisfactory for release until duplicate grouping tests are in agreement.

Only Anti-A and Anti-B Blood Serums meeting N. I. H. minimum requirements for these products shall be used and the technique used in grouping shall be that recommended by the manufacturer of the serums.

2. *Determination of the Rh type:* — Each bottle of citrated whole blood must be typed for Rh factor, using an Anti-Rh (Anti-D) typing serum. The result of the test must be recorded on the bottle label and on the laboratory record. Subtyping on the Rho (D) negative bloods may be carried out if desired, and the finding recorded on both the label and the laboratory record.

Only Anti-Rh Typing Serums meeting N.I.H. Minimum Requirements for these products shall be used and the technique used in typing shall be that recommended by the manufacturer of the serums.

3. *Titer of Group O Blood:* — The isoagglutinin titers of group O bloods are of importance when group O blood is used for transfusing recipients of other groups. Consideration may be given to reducing these titers by the addition of A and B group-specific substances to each bleeding. This practice is not universally approved by immunologists since the injection of these group-specific substances may give rise to an increase in the agglutinin titers in individuals of blood groups A, B, or O. If group-specific substances are added to blood, the addition must be made immediately prior to transfusion and the amounts added must be stated on the label and in the laboratory records.

An alternate method which avoids the use of group specific substances is the classification of group O bloods as low isoagglutinin titer or high isoagglutinin. The term "low titer" indicates a blood which has an isoagglutinin titer of not more than 1:200 when determined by the test tube centrifuge method or 1:40 by the well slide method. The finding shall be recorded, and shall be indicated on the bottle label. High titer blood is reserved for group O recipients or is used for purposes other than transfusion.

4. Serological tests:

1. A serological test for syphilis must be made on a specimen of blood taken from the donor at the time of bleeding. The blood shall not be used for transfusion unless the result of the serological test is negative, or the blood has been stored for at least 96 hours in the refrigerator.

2. Any serological technique as outlined by the respective authors in the "Manual of Serologic Tests"—1955 published by U. S. Public Health Service may be employed.

3. The Blood must be approved by the Georgia Department of Public Health in the same manner as laboratories are approved for performing blood tests.

5. Sterility Tests on Whole Blood:

A sterility test on whole blood must *not* be done. Rigid aseptic technique and maintenance of a sterile, closed system from donor to recipient is considered greater assurance of a sterile product than can be given by sterility tests which necessitate a break in the closed system.

It is recommended that the technique of handling blood be checked from time to time by performing a sterility test on out-dated blood and all bottles that are rejected for contamination.

6. Inspection for Release:

A careful visual inspection of each bottle of blood must be made by a technical member of the staff at regular intervals during storage and immediately prior to release for distribution. No bottle of blood may be released for use unless the color and physical appearance are normal and there is no suspicion of microbial contamination.

Cross Matching Blood for Transfusion

Materials and Equipment

- Wasserman tubes 13 x 100
- Recipient's clotted Blood (8 cc.)
- Donor's clotted Blood (Pilot tube)
- Human or Bovine Albumin 30%
- Water bath 37° C.
- Microscope
- Normal Saline

Every bottle of blood for transfusion must be cross-matched before it is administered to the recipient. Two methods of cross-matching must be done before bloods being tested are considered compatible. The following methods are required:

I. High Protein (Albumin) Method for Cross Matching bloods for transfusion. Use either technique a or b.

- High protein using human or bovine albumin.
 - Place two drops of the recipient's serum in a test tube marked RS and two drops of donor's serum in a tube marked DS.
 - Add 3 drops of albumin (30%) to each tube.
 - Add one drop of a 2% saline suspension of donor cells to the tube marked RS and one drop of a 2% suspension of recipient cells to the tube marked DS. No more than one drop of saline suspension may be added to either tube.
 - Incubate for five to ten minutes in a water bath at 37° C.
 - Centrifuge for 2 minutes at 1000 RPM or for 1 minute at 2000 RPM.
 - Dislodge the cell sediment very gently. Excessive shaking may break up agglutination.
 - Observe for agglutination with the naked eye and shake out the serum cell mixtures onto a glass micro slide spreading the contents over most of the slide. Observe under low power of the microscope for agglutination.
 - In order that the blood may be considered completely compatible, no agglutination should be present.

b. Procedure—Native Serum Method:

- Set up two test tubes and with a wax pencil mark one tube "RS" (Recipient serum) and the other tube "DS" (donor serum)
- Place two (2) drops of recipient's serum in tube marked "RS."
- Place two (2) drops of donor's serum in tube marked "DS."
- Add one (1) drop of a 5% suspension of donor's cells in his own group compatible serum to the tube marked "RS."

- e. Add one (1) drop of a 5% suspension of recipient's cells in his own group compatible serum to the tube marked "DS."
- f. Centrifuge immediately at 1000 R.P.M. for three minutes.
- g. If no agglutination occurs incubate for 30 minutes at 37° C. and centrifuge again. Examine for agglutination under low power of the microscope.
- h. If no agglutination is present bloods are considered compatible.

II. Saline

1. Set up two test tubes and mark in the same way as in above method.
2. Place two (2) drops of recipient's serum in tube marked "RS."
3. Place two (2) drops of donor's serum in tube marked "DS."
4. Add two (2) drops of a 2% suspension of donor's cells in normal saline to tube marked "RS."
5. Add two (2) drops of a 2% suspension of recipient's cells in his own or group compatible serum to tube marked "DS."
6. Centrifuge immediately at 1000 R.P.M. for three minutes.
7. Examine, macroscopically and microscopically. If no agglutination is present bloods are considered to be compatible.

In addition to the saline cross-match the indirect Coombs test should be done when indicated. The following conditions are considered to indicate the need for the Coombs test. (1) Individuals who have received transfusions in the past, or who are receiving multiple transfusions in a period of time longer than one week. (2) Women who are now pregnant or who have had previous pregnancies (3) Individuals having a history of unexplained transfusion reaction.

The technique for the Coombs test is as follows:

Using the same procedure as used in the saline cross-match procedure as outlined above in steps 1 through 7, continue as follows:

8. Incubate tubes for 30 minutes at 37° C.
9. Remove tubes from incubator and wash cells through (3) times with fresh saline. Decant as completely as possible after 3rd washing.
10. Add 2 drops anti-human (Coombs) serum; shake well.
11. Allow to stand at room temperature 15 minutes, centrifuge 1 minute at 1000 RPM.
12. Examine for agglutination, if none is present bloods are considered to be compatible.

Routine Investigation of Transfusion Reaction

Any Blood Bank cross-matching blood for transfusion should have the additional laboratory facilities required for determining whether or not a reaction is hemolytic and if hemolytic, for determining responsible antigen. The following are considered to be essential procedures:

1. Examine first urine voided after transfusion for evidence of hemolyzed blood. (Color, Albumin, Occult blood and microscopic examination)
2. Examine fresh specimen of patient's blood for evidence of hemolysis. (Collect specimen carefully in dry syringe, allow to clot in dry test tube; gently loosen clot and examine serum for pink, or red color of hemoglobin)
3. Check cross-match using blood directly from the bottle.
4. Sub-type patient and donor as indicated.

MINIMUM REQUIREMENTS FOR SATISFACTORY BLOOD

1. Donor must meet all requirements listed.

2. Blood must be drawn aseptically in a cool bottle using a closed system.
3. Blood must be stored at temperatures between 4 and 8° C. and never allowed to freeze.
4. Blood must be shaken properly during withdrawal and for 30 seconds after withdrawal is completed. Blood is preferably drawn into an inverted bottle.
5. Donor card, bottle and pilot tubes must be clearly marked with donor's name and donor number.
6. Blood must be transported under refrigeration and with minimum handling.
7. Serology must be negative.
8. Icterus index must be below 10.
9. Each bottle must be labeled with correct type and expiration date.

Reference Committee Recommendation—The Addendum Report of the Blood Banks Committee listing Minimum Requirements for Blood Banks was approved. Reference Committee No. 4 wishes to commend Warren B. Matthews and his committee for their work.

House of Delegates Action—Recommended adoption of the Addendum Report of the Blood Banks Committee on the Minimum Requirements for Blood Banks as presented by the reference committee, which was moved, seconded and adopted.

Liaison Advisory Board to the Georgia Society for Crippled Children

JACK C. HUGHSTON, *Chairman*

Those of us active in the care of the Crippled (Handicapped) Children feel there have been great strides in the development of organizations of care of these patients. One of the major advancements has been the cooperative effort of all organizations dealing with the care of the Crippled Children, so that available facilities could be used advantageously by all groups.

The National Foundation for Infantile Paralysis serves the acute polio cases and those suspected of being acute polio. The County Chapters of the National Foundation for Infantile Paralysis purchase services from the Warm Springs Foundation for some of the convalescent polio cases and severe chronic cases; whereas many other convalescent and chronic cases are given care under the auspices of the Crippled Children's Division of the Public Health Department and the Scottish Rite Hospital. Some polio cases are afforded a cooperative and simultaneous care from these organizations.

The Muscular Dystrophy Chapters will frequently purchase appliances and wheelchairs as a portion of the care of this special group of patients; while, at the same time, the Orthopedic follow-up of the case is under the auspices of the Crippled Children's Division of the Public Health Department, or the Scottish Rite Hospital.

Cerebral Palsy patients may be under the care of the Orthopedic Surgeon on the Crippled Children's Staff and, at the same time, these patients can be afforded special physical therapy, occupational therapy, speech therapy, and other special services, by the Public Health Department purchasing these special services from a Cerebral Palsy School, or by these special services donated by a Cerebral Palsy School, depending upon the particular case and its locality.

Convalescent care of many Crippled Children is greatly enhanced by the low rate of hospitalization offered by the Elks' Aidmore Hospital, in Atlanta, which works in close cooperation with the Crippled Children's Clinics. The Scottish Rite Hospital and Doctor Kite help the Crippled Children's Clinics of the Public Health Department by accepting some of the cases, when their own program is not momentarily overloading them.

The National Society for Crippled Children uses its funds from the Easter Seal Campaign for investigating, and directing, or caring for any case which may not fit into the care of the above agencies. They have recently developed studies of the facilities for care of all problems of Crippled Children, and of the needs yet to be met. Generally speaking, these have shown Georgia to stand with the best, though the best is not yet perfect, by any means. They also use their funds in research and in helping communities develop local or rehabilitation facilities, at the request of the appropriate county medical society. Education of Georgians in the special fields of supportive therapy for the Crippled Children takes considerable of the budget of the National Society for Crippled Children.

Many of the civic organizations give considerable aid to the care of the Crippled Children, usually by direct support, or donations to one of the above-mentioned organizations.

Thus, you can readily see that though there are many varied groups interested in the care of the Crippled Children, the various programs and interests have now developed to where they complement one another with their services rendered, rather than duplicate services and thus compete with one another. The aim of each has become the function of each, that is, "the best possible care of the crippled child."

It is fair to state that the greatest patient load and care is rendered by the Crippled Children's Staff and Division of the Public Health Department. Considerable progress and advancement has been made in this Division. The Crippled Children's Staff is composed of physicians in private practice who carry out this work because of their interest in Crippled Children, but who are rendered a small monthly stipend from the Public Health Department for their services. The Staff is composed of fourteen Orthopedic Surgeons, two Psychiatrists, two Plastic Surgeons, one Cardiologist and one Pediatrician. Other professional services are rendered on a "gratis" basis, or consultations and treatment in other fields of medicine are purchased on a minimal fee basis. These consultations are primarily in the general surgical and neuro-surgical fields. A Pediatrician attends almost every Clinic, gives supportive diagnostic aid in fields other than Orthopedic Surgery, and renders advice relative to general treatment in those cases not having a family physician, or not having the facilities of a Charity Clinic for this purpose in their respective counties.

The cases seen at the Clinics can be referred from any source. We much prefer that they be referred by the family physician, and when the referral is by other than the family physician we endeavor to find the name and address of the family physician. Whenever this information is available, we are supposed to contact the family physician and inform him of our findings and cooperate with him in the overall care of the patient.

At present, there are fourteen Clinic Districts. There is one special Physical Medicine Clinic. Future appointments to the Crippled Children's Staff will first depend on an existing vacancy by resignation of a present member, or by development of additional Clinics. The latter will necessarily occur with the increase in population, but the administrative cost of a Clinic is relatively great, so that additional ones will not be developed until the need is definite. Appointment to the Staff will necessitate that the physician be qualified by his Specialty Board. The selection of the person appointed will depend on his priority relative to when he made application, and will further depend on the location of the new Clinic District, relative to the location of the physician.

Burns have been cared for as much as was financially possible, as part of the Crippled Children's Programs; this is a general policy throughout most of the United States and in Crippled Children's Hospitals, for the burns of the extremities so frequently produce contractures across joints, that they have been considered under Orthopedic Surgery. We are unable to finance the care of the acute burn, in most instances, and generally they must be cared for under the same routine as the private patients of the locality. Once they become chronic, or ready for skin grafting, they can be taken on the Program. Occasionally, a bit of extra money will become available and then some of the acute burns can be hospitalized and cared for on the Program. We have been constant in our efforts to secure enough funds to allow care of the acute indigent burns.

Funds have been made available for beginning a Cardiac Program. This is within the Crippled Children's Division, but the cases are not followed through the established Orthopedic Clinics; they are handled through the Cardiac Clinics of the Georgia Chapter of the American Heart Association.

Other funds have been made available for beginning a Program of Seizure Control in Epileptic Patients. These patients will be evaluated by the Pediatricians in the District Orthopedic Clinics, and if they feel a complete workup of the case is indicated, the child will be referred to one of the three centers offering complete diagnostic study and EEG, these being Augusta, Atlanta and Columbus.

Year	Total Expenditures	No. of Children
1938 (3 months)	\$ 29,253.77	220
1939	187,023.89	701
1940	186,218.72	915
1941	203,268.45	1,071
1942	240,683.40	1,227
1943	153,501.53	1,013

Year	Total Expenditures	No. of Children
1944	174,371.38	1,040
1945	169,978.75	1,113
1946	203,335.26	1,043
1947	270,151.72	1,192
1948	358,620.99	1,408
1949	417,890.10	1,595
1950	432,981.68	3,642
1951	621,900.79	3,706
1952	708,131.85	4,601
1953	930,332.67	5,317
1954	711,650.00	5,955

A percentage breakdown of last year's budget is as follows:

Administrative	17.12
Professional:	
Hospitalization	44.00
Consultation fees	7.1
Appliances	12.7
Physical Therapy	2.
Convalescent Care	17.
Foster Home Care05

82.85

In the past we have frequently run out of money at the end of the fiscal year, that being April, May and June. This has been most disconcerting to both the patients and the doctors, as much of our operative load is frequently planned for the early summer while the children are out of school. Last year we were able to break down that part of the budget allocated for direct patient care, and each clinic district was able to know about how much they would have available; thus the doctors in charge of the Clinics were able to plan a rather even rate of expenditure, so that they could have the necessary funds available for the heavier months of early summer.

When the Crippled Children's Program was initiated, Dr. Fred Hodgson volunteered considerable time, in being the Director for the Crippled Children's Program; and under his direction the Program developed into a mature organization. He continued as Director until 1954, at which time he retired. It is impossible for any of us to give a sufficient compliment and thanks to him for his outstanding job performance in developing such an excellent Program over these years. When Dr. Hodgson retired, it was impossible for any one member of the Staff to fill this vacancy, as it necessitated so much time and effort. The solution was that the Public Health Department appointed a full time director of the Program for the administrative duties, to work in close cooperation with an Advisory Committee, selected from the Professional Staff. Dr. Mildred Scott served as the Medical Director for the Public Health Department for approximately eighteen months, and, at the present time, Dr. Guy Rice is filling this position. There has been the closest cooperation between the three-man Advisory Committee from the Professional Staff and the full time Director of the Public Health Department, with a continuation of progress and development of the Crippled Children's Program. Staff meetings are held at least quarterly, and these consist of a meeting of the entire Professional Staff with the Di-

rector and his officers, and there is a general discussion and decision relative to the policies affecting the best of care for the patients.

Our aim has never veered from the straight and narrow path toward the goal of achieving that which is to the best interests of the patients, or groups of patients. We will always appreciate constructive criticism relative to the Program, and we will always need your patience and full cooperation when things occasionally appear to go amiss.

I wish to thank you for allowing me the privilege and honor of serving as Chairman of your Crippled Children's Committee.

Reference Committee Recommendation—The Crippled Children's Committee Report was received as information.

House of Delegates Action—Recommended the receiving of the Crippled Children's Committee Report for information as recommended by the reference committee, which was moved, seconded and adopted.

Resolution on 1957 MAG Savannah Meeting

RUSKIN KING

The Medical Association of Georgia meets with almost phenomenal regularity, and exactly 75% of these meetings are held in such cities as Macon, Augusta, and Atlanta. The remaining 25% of these annual gatherings are convened in a spot near the sea which bears the invitingly beautiful name, Savannah.

We, of the Georgia Medical Society, like to feel, and perhaps not too vainly, that the mere name "Savannah" suggests relaxation, good fellowship, and profitable scientific experiences together.

At the April meeting of our Society, it was moved and unanimously carried that I, as president of the Society, be empowered to extend an invitation to the Medical Association of Georgia to hold its 107th Annual Session in Savannah in 1957.

This invitation I am most happy to extend—and "damned" be he who refuses it.

Ruskin King, M. D.
President
Georgia Medical Society
Savannah, Georgia

Reference Committee Recommendation—This committee recommends that we accept the gracious invitation of the Georgia Medical Society to hold the 107th Annual Session of the Medical Association of Georgia in Savannah, Georgia.

House of Delegates Action—Recommended adoption of the Resolution concerning the gracious invitation of the Georgia Medical Society for the 1957 MAG meeting as presented by the reference committee, which was moved, seconded and adopted.

Resolution on 1957 Shipboard Cruise Meeting

RUSKIN KING

WHEREAS, the Georgia Medical Society has unanimously invited the Medical Association of Georgia to hold its 1957 Annual Session in Savannah.

BE IT RESOLVED, that the Georgia Medical Society suggest the idea of holding the Annual Session

as a cruise of five (5) days from the port of Savannah, and,

BE IT FURTHER RESOLVED, that this recommendation be presented to the House of Delegates of the Medical Association of Georgia and referred to an appropriate Reference Committee.

Reference Committee Recommendation—This committee feels that this suggestion, as now submitted, is perhaps impractical because of the following reasons: space available (731); enforced attendance during the entire meeting; practicability of scientific exhibits; commercial exhibits and cost thereof. The cheapest accommodations in the material submitted were \$165.00 per person while the most expensive were \$395.00 per person. In order to use the full 731 spaces, some members would have to buy the most expensive tickets whether they wanted them or not.

Our committee recommends that this suggestion concerning the shipboard cruise meeting be referred to the MAG Council for additional study and action, including consideration of a shore session followed immediately by a shipboard session.

House of Delegates Action—Recommended the adoption of the 1957 Shipboard Cruise Meeting Resolution with the qualifications and recommendations submitted by the reference committee relative to this resolution with the matter being referred to the MAG Council as recommended by the reference committee, which was moved, seconded and adopted.

**REPORT OF REFERENCE COMMITTEE
NO. 5**

M. F. Arnold, Chairman

(The following reports as presented to this reference committee are printed in full with the reference committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 5 met in Room 929, Biltmore Hotel at 8:30 a.m., May 14, 1956. Present were: M. F. Arnold, Hawkinsville, chairman; Lee Howard, Jr., Savannah; Ralph Johnson, Rome; H. E. Weems, Perry; F. G. Eldridge, Valdosta; J. H. Nicholson, Madison; James A. Green, Athens; J. C. Paterson, Cuthbert; and, C. M. Mulherin, Augusta.

Second District Councilor

GEORGE R. DILLINGER

Medical Society activities in the Second District have improved during the past year. The two preceding district meetings in Camilla and Cairo were well attended and there were excellent scientific programs. These places of meeting were selected because of the inactivity of the local Society. Since that time, the local Societies have been active and interested in Organized Medicine. Another step forward is the consolidation of the Thomas and Brooks County Medical Societies into one.

There has been a slight gain in membership in the district, with 168 members as of December 31, 1955.

For the first time in the history of the Medical Association of Georgia a meeting of the Council was held in Thomasville in December, 1955. The only other State meeting held in the Second District was a meeting of the Medical Association of Georgia in Albany some thirty-five or forty years ago.

Physicians in the second district were interested in the legislation in the last meeting of the Legislature of Georgia and many of them contributed considerable time to the problems affecting medicine that went before that session.

SECOND DISTRICT MEMBERSHIP

Counties	Members December 31, 1955		Members December 31, 1954	
	MAG	AMA	MAG	AMA
Colquitt	16	10	17	11
Decatur-Seminole	18	14	15	13
Dougherty	40	24	40	20
Grady	10	5	8	5
Mitchell	12	8	13	8
Southwest Georgia	14	10	15	11
Thomas-Brooks	39	32	39	32
Tift	13	7	13	6
Worth	6	4	6	4
TOTAL	168	114	166	110

Reference Committee Recommendation—The Report of the Second District Councilor was received and approved.

House of Delegates Action—Recommended adoption of the Second District Councilor's Report as presented by the reference committee, which was moved, seconded and adopted.

Seventh District Councilor

D. L. WOOD

SEVENTH DISTRICT MEMBERSHIP

Counties	Members December 31, 1955		Members December 31, 1954	
	MAG	AMA	MAG	AMA
Bartow	8	8	9	8
Carroll-Douglas-Haralson	35	21	38	22
Chattooga	7	7	7	6
Cobb	44	39	38	31
Floyd	54	46	56	43
Gordon	12	10	12	10
Polk	17	10	17	10
Walker-Catoosa-Dade	31	22	27	21
Whitfield	20	13	20	13
TOTAL	228	176	224	164

Reference Committee Recommendation—The Report of the Seventh District Councilor was received by Reference Committee No. 5, and no recommendations were made.

House of Delegates Action—No action was taken.

Eighth District Councilor

NEAL F. YEOMANS

EIGHTH DISTRICT MEMBERSHIP

Counties	Members December 31, 1955		Members December 31, 1954	
	MAG	AMA	MAG	AMA
Altamaha	7	7	7	7
Coffee	15	8	14	8
Glynn	34	29	32	28
South Georgia	45	40	38	34
Telfair	9	7	10	9
Ware	46	36	51	41
Wayne	9	7	8	8
TOTAL	165	134	160	135

Reference Committee Recommendation—The Report of the Eighth District Councilor was received by Reference Committee No. 1, and no recommendations were made.

House of Delegates Action—No action was taken.

Treasurer

DAVID HENRY POER

The Treasurer's Report consists chiefly of the complete audit of Association finances as submitted by the auditing firm of Ernst & Ernst for the calendar year 1955; January 1st to December 31st inclusive. This audit is published below.

It should be emphasized that the financial status of the Association during the year 1955 has been excellent and the activity of the Council Committee on Audit and Appropriations should be commended. All Association expenditures are first included in a comprehensive budget which is approved by Council at its December meeting, and is published in your handbook. While the contingent fund which is included in the budget, takes care of unexpected expen-

ditures such as the recent flood damage to Association Headquarters, these are all approved in advance by the Committee on Audit and Appropriations and also by Council.

Last year the Association collected \$4,987.39 more than was expended. Three unexpected major items not budgeted, were, namely, the flood damage, expenses in regard to the Talmadge Hospital controversy, and expenses of the Legislative Committee. (Totaling approximately \$4,000).

The only source of extra income now seems to be an increase in space rates for commercial exhibits, and these can only be in proportion to the amount of service the Association can render. As stated elsewhere, this income will also be limited by the size of facilities available in other cities in Georgia.

Reference Committee Recommendation—The Treasurer's Report was accepted and approved.

House of Delegates Action—Recommended adoption of the Treasurer's Report as presented by the reference committee, which was moved, seconded and adopted.

STATEMENT OF ASSETS AND LIABILITIES — BY FUNDS

The Medical Association of Georgia

December 31, 1955

ASSETS	General Fund	Benevolent and Building Funds	Abner W. Calhoun Lectureship Fund	Combined
Cash on deposit and on hand	\$25,712.55	\$ —	\$ 155.71	\$ 25,868.26
Securities owned:				
At cost	—	50,000.00	6,101.85	56,101.85
At redemption prices	—	16,480.00	—	16,480.00
Accounts receivable	4,139.11	—	—	4,139.11
Travel deposit	425.00	—	—	425.00
Office Furniture and Equipment	6,608.75	—	—	6,608.75
Less Allowance for Depreciation	1,763.15	—	—	1,763.15*
	<u>\$ 4,845.60</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ 4,845.60</u>
Prepaid 1956 annual meeting expense . . .	1,275.00	—	—	1,275.00
TOTAL ASSETS	\$36,397.26	\$66,480.00	\$ 6,257.56	\$109,134.82
LIABILITIES				
Accounts payable for expenses	\$ 295.92	\$ —	\$ —	\$ 295.92
Membership dues held in suspense	271.25	—	—	271.25
Deferred income:				
Exhibitors fees—1956 annual meeting:				
Collected	6,327.50	—	—	6,327.50
Due from exhibitors	2,822.50	—	—	2,822.50
	<u>\$ 9,150.00</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ 9,150.00</u>
TOTAL LIABILITIES	\$ 9,717.17	\$ —	\$ —	\$ 9,717.17
EXCESS OF ASSETS OVER LIABILITIES .	<u>\$26,680.09</u>	<u>\$66,480.00</u>	<u>\$ 6,257.56</u>	<u>\$ 99,417.65</u>

STATEMENT OF INCOME AND EXPENSE — BY FUNDS

The Medical Association of Georgia

Year ended December 31, 1955

INCOME	General Fund	Benevolent and Building Funds	Abner W. Calhoun Lectureship Fund	Combined
Membership dues:				
Year 1955	\$54,105.00	\$ —	\$ —	\$54,105.00
Prior years	332.50	—	—	332.50
Less allocated to subscriptions to The Journal . .	9,005.00*	—	—	9,005.00*
	<u>\$45,432.50</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$45,432.50</u>
Net Income from The Journal—				
as shown by schedule	4,436.52	—	—	4,436.52
Interest on U. S. Savings Bonds:				
Received—Note A	1,250.00	—	—	1,250.00
Increase in redemption values	—	558.00	—	558.00
Interest received on savings share accounts . . .	400.00	—	—	400.00
Dividends on stock owned	—	—	263.92	263.92
TOTAL INCOME	<u>\$51,519.02</u>	<u>\$558.00</u>	<u>\$263.92</u>	<u>\$52,340.94</u>
EXPENSE				
Salaries:				
Secretary and treasurer	\$ 4,000.00	\$ —	\$ —	\$ 4,000.00
Executive secretary	6,000.00	—	—	6,000.00
Assistant executive secretary	4,200.00	—	—	4,200.00
Clerical	7,073.60	—	—	7,073.60
Less allocated to Journal	3,000.00*	—	—	3,000.00*
	<u>\$18,273.60</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$18,273.60</u>
Lecture at annual meeting	\$ —	\$ —	\$250.00	\$ 250.00
Trustees fee	—	—	13.78	13.78
Expenses of 1955 annual meeting less fees from exhibitors of \$8,100.00	272.36	—	—	272.36
Administrative and other expenses—				
as shown by schedule	28,332.62	—	—	28,332.62
TOTAL EXPENSE	<u>\$46,878.58</u>	<u>\$ —</u>	<u>\$263.78</u>	<u>\$47,142.36</u>
	<u>\$ 4,640.44</u>	<u>\$558.00</u>	<u>\$.14</u>	<u>\$ 5,198.58</u>
OTHER INCOME				
Received from AMA for services, postage, etc. . .	\$ 530.97	\$ —	\$ —	\$ 530.97
	<u>\$ 5,171.41</u>	<u>\$558.00</u>	<u>\$.14</u>	<u>\$ 5,729.55</u>
OTHER DEDUCTION				
Equipment ruined by flood charged off—Note B .	\$ 184.02	\$ —	\$ —	\$ 184.02
NET INCOME	<u>\$ 4,987.39</u>	<u>\$558.00</u>	<u>\$.14</u>	<u>\$ 5,545.53</u>

NOTE A—On May 10, 1953, the Council authorized interest received on U.S. Savings bonds held in the Benevolent and Building Funds to be recorded in the General Fund.

NOTE B—Other loss and damage due to flood included in above statement amounted to \$949.18.

Council Committee on Auditing and Appropriations

W. BRUCE SCHAEFER, *Chairman*

The Committee on Auditing and Appropriations as appointed by Council for 1955 and 1956, has met at regular intervals as well as irregular intervals through the year. The meetings have all been very harmonious and the Committee has been in accord on practically all expenditures. The office staff have been very cooperative in helping us with our figures. We have set up this year a budget that has been reviewed every three months to see how the expenditures and how the income have compared. The 1955 budget has been more than we had anticipated, but so has our income been more than we had anticipated. The correct figures have not come back from the auditor at the time of this writing, but they will be given in the Report of the Secretary-Treasurer.

The 1955 budget was set up at approximately \$80,000. The expenditures have run around \$87,000, which gives us a deficit there of \$7,000 in the budget that had been originally set up, but the income has been enough to take care of that and the 1956 budget has been set up at around \$90,000. There are many things that have come up during the year such as the flood which cost us extra money; we are having to pay more legal fees due to the increase in lawsuits in the State of Georgia among our members. I am happy to report at this time, however, that the Association operated during the year and accumulated a net gain of approximately \$5,000 after taking care of this operating expenses. This gives us an operating reserve to start the year 1956 out with. The budget as submitted by this Committee for the operation of 1956 has been approved by Council at its December, 1955, meeting at Thomasville, and is printed below. I would like to express my thanks to the other members of the Committee, and again thank Headquarters Staff for helping us with this Committee.

	1955 Budget	Income and Dec. 9, 1955 Disbursements	1956 Tentative Budget
INCOME			
Income from Dues . . .	\$52,500.00	\$56,582.50	\$55,500.00
Journal & Advertising . .	19,000.00	23,206.91	23,000.00
Exhibitor Fees A.S. . . .	6,500.00	8,100.00	9,000.00
Int. & AMA Service . . .	1,700.00	1,830.97	2,000.00
	\$79,700.00	\$89,720.38	\$89,500.00

DISBURSEMENTS			
1. <i>Salaries</i>	\$25,600.00	\$25,383.33	\$26,600.00
Temporary Talent . . .		240.27	
		\$25,623.60	
2. <i>Fixed Allotments</i>			
Pension Payments . . .	\$ 2,400.00	\$ 1,100.00	\$ 1,200.00
Honorarium—President .	1,000.00	1,000.00	1,000.00
Attorneys Retainer . .	1,200.00	1,200.00	1,200.00
Annual Audit	400.00	400.00	400.00
Cont. FCMS	1,500.00	1,400.00	1,500.00
Ins. & Bonds Per. . . .	200.00	20.40	100.00
Woman's Auxiliary . . .	1,300.00	1,300.00	1,300.00
Hetter Health Coun. . .	1,200.00	1,200.00	1,200.00
	\$ 9,200.00	\$ 7,620.40	\$ 7,900.00

	1955 Budget	Income and Dec. 9, 1955 Disbursements	1956 Tentative Budget
3. Journal Publication			
Engraving & Cuts . . . \$	800.00	\$ 719.79	\$ 800.00
Editorial Asst.	100.00	30.00	150.00
Stationery	350.00	316.89	650.00
Postage	500.00	509.80	500.00
Clipping Service	250.00	184.90	250.00
Add. & Supplies	200.00	144.36	200.00
Copyright	50.00	48.00	50.00
Printing	20,000.00	21,362.20	22,000.00
	\$22,250.00	\$23,323.94	\$24,600.00

4. Headquarters Expense			
Travel	\$ 4,000.00	\$ 4,487.66	\$ 5,000.00
Meetings	500.00	490.05	500.00
Stationery, Printing, and Supplies	1,000.00	1,047.28	1,200.00
Postage	800.00	926.64	1,000.00
Tel. & Tel.	1,600.00	1,938.84	2,200.00
Depreciation	500.00		500.00
Office Sup. & Exp. . . .	600.00	643.07	600.00
Dues & Sub.	200.00	118.11	200.00
Janitor Service	300.00	300.00	300.00
Payroll Tax	250.00	502.67	600.00
Sundry	300.00	562.26	600.00
	\$10,050.00	\$11,016.58	\$12,700.00

5. Annual Session			
Expense	\$ 6,500.00	\$ 8,177.84	\$ 9,000.00

6. Committee Expense			
1. Rural Health . . . \$	350.00	\$ 169.93	\$ 200.00
2. Medical Defense . . .	200.00	129.05	200.00
3. Legislation	500.00	935.67	1,000.00
4. Maternal Welfare . . .	150.00	123.31	200.00
5. Industrial Health . . .	100.00	125.00	100.00
6. Public Relations . . .	1,000.00	797.08	1,000.00
7. Ins. & Economics . . .	600.00	797.92	300.00
8. Awards	150.00	137.75	150.00
9. AMEF	150.00	—	—
10. Veterans Affairs . . .	100.00	—	150.00
11. Hosp. Relations	100.00	10.20	150.00
12. Hist. & Vital Stat. . .	300.00	.	300.00
13. Med. Civil Prep.	50.00	—	50.00
14. Blood Banks	50.00	—	50.00
15. Mental Health	—	—	250.00
16. GP of the Year	—	—	100.00
	\$ 3,800.00	\$ 3,220.91	\$ 4,200.00

Flood Replacements . . .	\$ 949.18	
Eugene Talmadge Comm.	920.06	
Salk Vaccine	269.84	
Dictaphone	837.94	
Addressograph & File . .	1,553.46	
Typewriter	209.83	
Desk and Chair	100.00	
Tables for Conf. Room . .	96.25	
File Cab., Chair, Heater	128.73	

TOTAL DISBURSEMENTS .	\$77,400.00	\$84,048.56	\$85,000.00
Contingent Fund . . . \$	2,300.00	\$ 5,671.82	\$ 4,500.00
Bank Bal. (12-1-54) . .	\$22,959.55	\$28,382.43	

Reference Committee Recommendation—The Report of the Audit and Appropriations Committee was accepted and approved.

House of Delegates Action—Recommended adoption of the Report of the Audit and Appropriation Committee as presented by the reference committee, which was moved, seconded and adopted.

History and Vital Statistics Committee

J. CALVIN WEAVER, *Chairman*

The members of the Committee are so distantly separated that it is practically impossible to have a meeting of the Committee. The report this year necessarily cannot be much different from in years past.

As Chairman of the Committee, and as you already know, I have been working on the medical history of Georgia and am glad to say that definite progress has been made during the past year. The portion of the history covering Georgia as a Colony and also the portion on Georgia as a Province have had a final writing and typing. This taken us through the Revolutionary War period. The material from then on through the Civil War is in hand, but will require a lot of rearranging and rewriting to whip it in line for the final typing. Unless one has undertaken such a job as this, he cannot have any idea how much research, reading and time it takes to separate the dross from the gold and to get it in shape for a worthwhile history.

In doing this work, I have been very careful to try to get everything as accurate as possible and to try not to use tradition for history.

As the end of this undertaking seems to be in the not too distant future, the question arises as to what can be done about the publication of the book and also whether the Association will be willing to remunerate me for the work I have done in writing this history. If and when the work is completed (and I do believe it will be a worthwhile medical history of Georgia) and in the light of a past experience that the Association had in which \$1,000 was practically thrown away, I think that before the Association takes any definite steps about any remuneration to me for writing this history, the manuscript should be submitted to a committee of three, to be appointed by the President, and let these three men read it and pass on whether it would be worthwhile publishing it. If they decide it is worthwhile, then I feel that I should have a reasonable remuneration for writing it and then the Association could go about publishing it in anyway they see fit. I have looked into the cost of publication rather recently, and I find that it has gotten to be an expensive affair to publish any book. For a history of around 500 pages, one estimate has been made of \$5,000 for 1000 copies. Only yesterday I received a price quotation of \$10.00 for a new county history that is supposed to come off the press in May. I think that if a small county history will sell for \$10.00 a copy that a larger history covering a great deal more ground such as the state medical history will be will have to sell for at least that much.

By way of recommendations, occasionally an historical article comes out in the medical *Journal* and we, of course, are always glad to see anyone interested in medical history. But, in a couple of articles I have noticed that some of the details are not entirely accurate. I think of all things one of the first essentials of history is to have it accurate and on this account, I would recommend that before the *Journal*

publishes any more articles on medical history that the author be required to submit the manuscript to some committee to pass on the accuracy of it before it is published; I suppose that the Committee on Medical History would be an appropriate committee to refer it to.

There are no other recommendations that come to mind. I would like the House of Delegates to think these matters over regarding the publication of the medical history of Georgia.

Reference Committee Recommendation—The report of the History and Vital Statistics Committee was accepted and approved, and it was suggested that a letter be written commending Dr. Weaver for his excellent work in preparing the medical history of Georgia.

House of Delegates Action—Recommended adoption of the History and Vital Statistics Committee Report and the recommendation of the reference committee pursuant to the report, which was moved, seconded and adopted.

Maternal and Infant Welfare Committee

PETER HYDRICK, *Chairman*

The Committee has had one meeting this year, held in August 1955 at which time all the maternal deaths were reviewed that had questionnaire forms returned to the Committee. A report of these findings was published in the January 1956 issue of the *Journal of the MAG*.

The 1955 maternal deaths have at present not all been received and questionnaires are still being received. As soon as all deaths have been received and all questionnaires mailed and adequate time allowed for answering, they will be reviewed and a report published in the *JMAG*.

Since the last meeting, a new questionnaire has been completed which has numerous more questions than the original form. This, when completed, gives the committee better and more detailed information and enables them to more accurately determine whether death was preventable or non-preventable. It is disappointing that the physicians who have had maternal deaths to occur either refuse to answer these questionnaires or inadequately answer them. These forms are done on an anonymous basis for physician and location, and it is not the intent of the Committee to criticize any person but to try to better understand the conditions that exist and all the underlying causes of these deaths, and by so publishing this information to help all forces involved to improve the situation and lower the mortality rate.

The Committee is now ready to start on a fetal death survey and steps are being taken to initiate this program.

The Committee is working with the possibility of obtaining a physician who would travel the State disseminating information on obstetrics.

Recommendations—To continue reviewing individual anonymized maternal deaths in order to make broad or individual recommendations.

To start a similar review of infant deaths with the same purpose in mind.

To continue in an advisory capacity to the Health Department on request.

To promote increased lay and professional knowledge of the responsibility for the welfare of Georgia's mothers and infants.

Reference Committee Recommendation—The Report of the Maternal and Infant Welfare Committee was accepted and approved.

House of Delegates Action—Recommended adoption of the Report of the Maternal and Infant Welfare Committee as presented by the reference committee, which was moved, seconded and adopted.

ADDENDUM

Nurses Obstetrical Training

DAVID HENRY POER, *Secretary*

It is recommended that serious study and investigation be given the consideration of the development of a program to train nurses to perform normal obstetric deliveries when approved by the local county medical society. It is apparent that midwives are decreasing in number, and at best the majority of midwives are trained largely by experience. It is also apparent that obstetric deliveries in hospitals are increasing, and in many cases the average general practitioner can ill afford "waiting time" in delivery in proportion to his patient load. It should also be noted that the incidence of cesarean sections is increasing in the small community hospital.

These factors point out the need for adequately trained nurses to take care of normal deliveries in hospitals or maternity shelters under close medical supervision, and this need should be further studied and recommendations made pursuant to this problem.

Reference Committee Recommendation—The Addendum to the Maternal and Infant Welfare Committee Report pertaining to Nurses Obstetrical Training is accepted and approved with the amendment that this apply only to indigent patients.

House of Delegates Action—Recommended adoption of the Addendum to the Maternal and Infant Welfare Committee Report pertaining to Nurses Obstetrical Training with the qualifications so listed and presented by the reference committee, which was moved, seconded and adopted.

ADDENDUM

Advisory members to Maternal and Infant Welfare Committee

PETER HYDRICK

This is to request that provisions be made for the professors of obstetrics and of pediatrics at the schools of medicine in this State to have official status as Advisors to the Committee on Maternal and Infant Welfare.

By virtue of their professional status and their relations with graduate physicians throughout the state they can be extremely helpful if they are kept informed and participate in an advisory capacity, not only in review of selected maternal and infant deaths, but in other matters in which they might be helpful.

We recognize that in many states these persons are an integral part of the committee, but the existence of two schools in this state makes for a cumbersome committee.

Since we feel that they really have a contribution to make as advisors, we are requesting them in this capacity.

Reference Committee Recommendation—Addendum to the Maternal and Infant Welfare Committee Report pertaining to Advisory Members to the Maternal and Infant Welfare Committee is accepted and approved.

House of Delegates Action—Recommended adoption of the Addendum to the Maternal and Infant Welfare Committee Report pertaining to Advisory Members to the Maternal and Infant Welfare Committee as presented by the reference committee, which was moved, seconded and adopted.

Industrial Health Committee

DUNCAN SHEPARD, *Chairman*

The Industrial Health Committee of the Medical Association of Georgia was represented at the 16th Annual Conference of Industrial Health in Detroit in January 1956 by Dr. Allen M. Collinsworth. Dr. Collinsworth, in a meeting of the committee, summarized the work of the Industrial Health Congress and pointed out that the theme of the whole program was a study of absenteeism. I am forwarding as a part of this report Dr. Collingsworth's excellent summary of the activities of the meeting.

The Committee has studied at length the problem of hiring the handicapped in industry and has found the following difficulties which should be corrected.

1. Industry is urged on all hands to hire the physically handicapped and this industry is doing to a greater extent than in former years.

2. Industry is being penalized for hiring the handicapped by the findings of Industrial Boards if one of the handicapped workers is injured; large indemnities are being paid for aggravation of pre-existing disabilities. As long as such conditions exist employers will not hire as many handicapped workers as it is possible for them to do.

Recommendations—1. That the Public Legislation Committee of the Medical Association of Georgia have introduced into the State Legislature a resolution (below) to promote the hiring of physically handicapped workers.

2. That this resolution make some provision that such workers be examined and that the physical handicaps be described at the time of hiring and such handicaps be exempted from further indemnities on the part of the employer.

The Industrial Health Committee would be happy to cooperate with the Committee on Legislation in any way in drawing up such a bill.

Suggested Resolution:

Whereas, it has come to the attention of the members of the Committee on Industrial Health of the Medical Association of Georgia that a serious situation exists in the field of pre-employment and re-employment examination as respects the approval for employment of persons afflicted with cardiovascular disease, hernia, diseases affecting the back and spine and its associated musculo-skeletal nervous system, and any other disease or previous injuries which may be partially or potentially disabling, but which may not render the applicant totally disabled for certain types of employment; and,

Whereas, it has further come to the attention of this Committee that under the present laws of the State of Georgia, there is no way that such an individual, so afflicted, may be employed without the employer risking full liability under the present Workmen's Compensation Laws of Georgia for aggravation of such pre-existing disease or injury; and,

Whereas, it has further come to the attention of this Committee that because of this situation many applicants for employment are being necessarily rejected and returned to the ranks of the unemployed, when they might be utilized in some capacity to the advantage of industry, society and themselves in spite of their handicap;

Therefore, *Be It Now Resolved* that the Association instructs its Legislative Committee to consider this situation and to formulate and sponsor appropriate legislation for the alleviation thereof; and,

It Is Further Resolved that it be suggested to the Legislative Committee that they consider the formulation and sponsoring of legislation, which will permit an applicant for employment or reemployment, who is so afflicted, to sign a waiver of rights to compensation benefits which might result from aggravation of such pre-existing condition in the course of further employment.

Reference Committee Recommendation—The Report of the Industrial Health Committee was accepted and approved.

House of Delegates Action—Recommended adoption of the Report of the Industrial Health Committee as presented by the reference committee, which was moved, seconded and adopted.

Veterans' Affairs Committee

HARTWELL JOINER, *Chairman*

This is a very brief report in that our work has been limited absolutely to the showing of film three times.

The only other work done has been purely in association with getting up reports for the AMA.

These problems have arisen, having a tremendous influence on our relationship to Veterans, namely the extension of services to the families of service men. Correspondence between the Committee to the Medical Association of Georgia and to the AMA is rather frequent. It is a good liaison and reports and results will be coming from AMA Headquarters instead of from the State organizations.

There has been a continuation of correspondence with Representatives in Washington, and though the outlook for any immediate accomplishment in our aims is rather doubtful, there is the impression that this year is a good one to get some commitments, perhaps. The chairman of the committee proposes to correspond with every County Secretary and District Secretary as rapidly as reports come in from AMA Headquarters. The reports will be in an advisory capacity that they may be used on the Representatives in order to make them commit themselves to the Physicians and to the people on their standing in regards to medical service to the Veterans.

Reference Committee Recommendation—The Report of the Veterans Affairs Committee was accepted and approved.

House of Delegates Action—Recommended adoption of the Report of the Veterans Affairs Committee as presented by the reference committee, which was moved, seconded and adopted.

Abner Wellborn Calhoun Lectureship Committee

GLENVILLE GIDDINGS, *Chairman*

I have spoken with Dr. Phinzy Calhoun, and we are in agreement in having this lecture held every other year. It will be nice to alternate this lecture with the McRae Lecture. You may recall that the Calhoun Lecture was given at the Augusta meeting of the Association last May. With this agreement in view, we would not have a lecture for the coming meeting in Atlanta.

Reference Committee Recommendation—The Report of the Abner Wellborn Calhoun Lectureship Committee was accepted and approved.

House of Delegates Action—Recommended adoption of the Report of the Abner Wellborn Calhoun Lectureship Committee as presented by reference committee, which was moved, seconded and adopted.

Woman's Auxiliary to the

Medical Association of Georgia

MRS. ROBERT C. MAJOR, *President*

Greetings from the Woman's Auxiliary to the Medical Association of Georgia!

"Active Leadership in Community Health" has been the theme of Auxiliary efforts in every county medical auxiliary in Georgia during the past year.

Organization of Polk County Auxiliary brought the number of county auxiliaries to forty.

The Auxiliary was represented at the Georgia Conference preceding the White House Conference on Education, at the regional state Civil Defense meetings, at the Family Life Conference, and at meetings of the Better Health Council and of the Division of Maternal and Child Health of the State of Georgia Department of Public Health.

Auxiliary members have given staff work as well as participated in solicitation of funds for tuberculosis, polio, cerebral palsy, cancer, crippled children, mentally retarded children, muscular dystrophy, heart and community chest drives. Many members have assisted with audio-visual examinations of school children. Others have assisted in establishing and maintaining special classes in public schools for the cerebral palsied, deaf, blind and other physically handicapped children. Others have assisted in establishing and maintaining schools for the mentally retarded children. Volunteers have served in pre-natal and well baby clinics. Many serve as Gray Ladies, instructors in First Aid and Home Nursing, and as leaders in Girl and Boy Scout and YWCA and YMCA programs. One Auxiliary has recruited colored women to be taught midwifery by qualified members of the County Health Department.

Auxiliaries have given layettes, toys, books, and clothing to hospitals for charity patients. One auxiliary purchased, wrapped and sent Christmas packages to be distributed to the children at Gracewood and Milledgeville State Hospital. Another auxiliary purchased and dressed dolls which were sent to the children of these two institutions at Christmas.

Cancer Gift-and-Loan Closets were maintained by some auxiliaries. Others gave Christmas gifts of toilet articles, homemade candy, books and the like to indigent cancer patients.

The Auxiliary program, presented to and approved by the Advisory Committee from the Medical Association of Georgia, has offered many opportunities for active leadership in community health, as outlined in the following paragraphs.

Many of the several phases of SAFETY have been emphasized, with some auxiliaries stressing bicycle safety, some home safety, others child safety and still others school and bus safety, depending on the needs

of the community. Safety films were furnished by auxiliaries to be shown in grammar and junior high schools.

Much time and talent has been expended by auxiliary members to further our NURSE RECRUITMENT program. County auxiliaries have helped organize and have sponsored Future Nurses Clubs in the high schools. Several county auxiliaries have nurse scholarships and loans. A brochure published by the Georgia Nurses Association containing information about the twelve nurses training schools in Georgia has been distributed to every county auxiliary for use in this program.

The CIVIL DEFENSE program has inspired many members to take courses in First Aid and Home Nursing. Others have given service to the Ground Observer Corps and Filter Centers. Through Auxiliary efforts many homes in Georgia now have first aid kits as recommended by Civil Defense authorities, home shelters and emergency supplies of food and water. The "Home Protection Exercises" have been studied and demonstrated by auxiliaries.

Because LEGISLATION basically touches the foundation of our lives, Auxiliary members have been keenly interested in state and national legislation pertaining to health. Auxiliaries and their members cooperated with the Medical Association of Georgia by sending letters and telegrams and by personal communication with legislators concerning repeal of the Naturopathy Act of 1950.

Public forums, radio programs and plays have been sponsored by county auxiliaries in an effort to inform and interest the public in the MENTAL HEALTH problems facing the state and nation.

County Auxiliaries have contributed original historical or biographical papers to our RESEARCH AND ROMANCE IN MEDICINE file.

The first request made of the Woman's Auxiliary by the American Medical Association was to promote interest in *Hygeia*, now known as *Today's Health*. The Auxiliary has responded with enthusiasm and today this magazine will be found in the waiting room of most of the doctors and dentists in Georgia and in public and school libraries, beauty parlors, barber shops, shoe repair shops and other public places. Auxiliaries have given subscriptions to schools, both colored and white, community centers, hospital waiting rooms and bookmobiles.

Celebration of DOCTOR'S DAY has become a tradition with every county auxiliary in the state. On that day, March 30th, each doctor is given a red carnation; wreaths and flowers are placed on the graves of deceased physicians; and fitting parties honor the occasion.

The AMERICAN MEDICAL EDUCATION FUND will receive a contribution of \$748.00 from your Auxiliary this year. Many auxiliaries include a contribution to this fund as part of the dues of each member. The Auxiliary has urged the use of In Memoriam and In Appreciation cards as a means of raising money for this fund.

The Auxiliary STUDENT LOAN FUND has made four loans totalling \$1,900.00, to medical students this year. Because of limited funds we were unable to grant loans to many other worthy students. There are seventeen loans outstanding at this time, totaling \$8,371.88.

The STATE HANDBOOK which was compiled last year for the use of State Officials and county presidents was distributed early this year. A copy was sent to every state president in the nation as well as to all national officers. Many states are using Georgia's handbook as a model in preparing their own.

Four issues of the AUXILIARY NEWS will be published this year. The NEWS is sent to every Auxiliary member in the state as well as to Auxiliary presidents and editorial chairmen in other states. Through the NEWS, members keep informed of Auxiliary activities in the state.

The Auxiliary gratefully acknowledges the financial support of the Medical Association of Georgia which makes possible both the publication of the NEWS and the Annual Report and the attendance of the president and president-elect at the National Conference of these officers in Chicago. The time and counsel given by the Advisory Committee and the assistance received from the Executive Secretary and staff are also sincerely appreciated.

Reference Committee Recommendation—The Report of the Woman's Auxiliary to the Medical Association of Georgia was accepted and approved.

House of Delegates Action—Recommended adoption of the Report of the Woman's Auxiliary to the Medical Association of Georgia as presented by the reference committee, which was moved, seconded and adopted.

ADDENDUM

Thank you for the opportunity to give you this additional information which was not available at the time the Auxiliary Report was written for your handbook.

There are forty organized county auxiliaries in Georgia, with a total membership of 1522. There are still many medical societies without an auxiliary. We need your interest and help in order to accomplish the goal of "every doctor's wife an Auxiliary member."

Subscription to *Today's Health* magazine shows a substantial increase, with 102% of our quota having been reached. If you are not already a subscriber to this magazine, won't you become one?

Auxiliary contributions to the American Medical Education Fund this year amount to \$1,327, more than double the figure of last year. Much of this money has been raised through the use of "in appreciation" and "in memoriam" cards.

Our Student Loan Fund added five new loans amounting to \$2,160 this year, making a total of 17 outstanding loans with a total value of \$8,644.78.

Please borrow and read the copy of our Annual Report which your wife will receive at this meeting. You will be amazed at the amount of public relations work that she and other auxiliary members are doing.

Thank you for your continued financial support and for the valuable assistance received from the Executive Secretary and staff and the MAG Headquarters Office.

Reference Committee Recommendation—The addendum to the Report of the Woman's Auxiliary to the Medical Association of Georgia is accepted and approved.

House of Delegates Action—Recommended adoption of the Addendum to the Report of the Woman's Auxiliary to the Medical Association of Georgia as presented by the reference committee, which was moved, seconded and adopted.

Resolution on Hospital Chaplains

PHILIP H. NIPPERT

(For Fulton County Medical Society)

WHEREAS, an excellent state of medical service is rendered patients in hospitals by physicians and surgeons duly licensed to practice medicine; and,

WHEREAS, there exists a strong bond in the field of medicine and theology which should be strengthened to provide a more all-inclusive patient care in hospitals; and,

WHEREAS, certain hospitals have recognized the value of cooperation between the two professions in providing patient care;

THEREFORE, BE IT RESOLVED, that the House of Delegates of the Medical Association of Georgia go on record as strongly urging all hospitals in the State of Georgia to become cognizant of this dual approach to patient care; and,

BE IT FURTHER RESOLVED, that hospitals in the State of Georgia be requested to consider the staff addition of a full time chaplain and when possible consider the establishment of a chapel within the hospital; and

BE IT FURTHER RESOLVED, that this resolution be referred to the Georgia Hospital Association, Governing Boards, and Hospital Administrators Association for action.

Reference Committee Recommendation—The reference committee accepts and approves the Resolution on Hospital Chaplains.

House of Delegates Action—Recommended adoption of the Resolution on Hospital Chaplains as presented by the reference committee, which was moved, seconded and adopted.

Resolution on AMA Regional Meetings

DON F. CATHCART

(Fulton County Medical Society)

WHEREAS, The American Medical Association offers to the physicians an excellent scientific, ethical, legal and public relations program twice each year; and,

WHEREAS, many physicians, for various reasons, cannot avail themselves of these programs; and,

WHEREAS, all physicians need to know the many problems facing medicine today; and,

WHEREAS, a closer relationship among physicians, medical societies and allied organizations is essential to preserve our high medical standards; and

WHEREAS, the best way to accomplish this, is through education, open forums and personal contact;

THEREFORE, BE IT RESOLVED, that the American Medical Association, through its Board of Trustees, be asked to institute a series of small regional meetings to supplement these semi-annual meetings; and

BE IT FURTHER RESOLVED, that a trial meeting be held for the Southeastern Region in Atlanta, Georgia, at a time deemed suitable by the Board of Trustees and its headquarters convention staff in cooperation with the Medical Association of Georgia and so instruct our AMA Delegates.

Reference Committee Recommendation—The Resolution on AMA Regional Meetings was accepted and approved.

House of Delegates Action—Recommended adoption of the Resolution on AMA Regional Meetings as presented by the reference committee, which was moved, seconded and adopted.

Resolution on Workmen's Compensation

PAUL L. BRADLEY

(Whitfield County Medical Society)

WHEREAS, the present Georgia Workmen's Compensation Law now allows the employer to choose the physician in cases of industrial injury; and,

WHEREAS, this right is frequently exercised to force an employee to consult a doctor not of his choosing; and,

WHEREAS, there are medical, and, at times, obstetrical reasons why a patient should be allowed to go to his or her family physician when injured on the job to say nothing of the improved doctor-patient relationship which prevails when a patient has that democratic American right to choose his own physician; and,

WHEREAS, one of the greatest deterrents to socialized medicine is the continuance of the long established policy of the American Medical Association for the complete freedom in the choice of physician; and,

WHEREAS, the American Medical Association adopted by resolution in the November, 1955, meeting in Boston, that local medical organizations seek adoption of statutory provisions to the end that all patients subject to workmen's compensation laws have the right to select a physician in the community willing and able to perform the essential services

THEREFORE, BE IT RESOLVED, that the Medical Association of Georgia will actively support an act to amend Title 114 of the Code of Georgia of 1933 which relates to Workmen's Compensation and particularly 114-5 relating to medical attention and physical examinations by amending Section 114-501 relating to medical and other treatment so as to allow the employee to select the attending physician.

Reference Committee Recommendation—The Resolution on Workmen's Compensation is accepted and referred to the Medical Association of Georgia Council for study and action.

House of Delegates Action—Recommended the adoption of the reference committee recommendation concerning the Resolution on Workmen's Compensation, which was moved, seconded and adopted.

Resolution on Automobile Safety

EUSTACE A. ALLEN

(Delegate to the AMA)

WHEREAS, the medical profession has and must continue to fulfill its pledged responsibility to maintain and improve the health of the general public; and,

WHEREAS, the medical profession has made outstanding advances in the art and science of medicine to the extent that public in these United States enjoy the highest standards of health ever attained; and,

WHEREAS, there is yet a medical problem of major proportion facing the profession which has been neglected; and,

WHEREAS, this medical problem—the killing and maiming of people on our highways affects more persons than does all illness known today

THEREFORE, BE IT RESOLVED, that the House of Delegates of the Medical Association of Georgia request that the American Medical Association lend every effort, morally and financially, to combat this problem through its Board of Trustees, Councils and Committees and its component state medical associations, and

BE IT FURTHER RESOLVED, that the American Medical Association conceive and endorse a comprehensive program of automobile safety during 1956-57, and report to the AMA House of Delegates at the June 3-7, 1957 Session, New York City, and

BE IT FURTHER RESOLVED, that the AMA request each component state medical association to set-up a committee on automobile safety for similar purposes during 1956-57.

Reference Committee Recommendation—The reference committee accepts and approves the Resolution on Automobile Safety.

House of Delegates Action—Recommended the adoption of the Resolution on Automobile Safety as presented by the reference committee, which was moved, seconded and adopted.

REPORT OF REFERENCE COMMITTEE NO. 6

B. L. Shackleford, Chairman

(The following reports as presented to this reference committee are printed in full with the reference committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 6 met in the MAG Headquarters Office, Academy of Medicine, at 8:30 a.m., May 14, 1956. Present were B. L. Shackleford, Atlanta, chairman; Glenn E. Seymour, Albany, vice-chairman; Fred H. Simonton, Chickamauga, secretary; R. C. McGahee, Augusta; C. Roy Williams, Wadley; J. B. Mercer, Brunswick; and J. W. Chambers, LaGrange, *ex-officio* member.

Constitution and By-Laws Committee

J. W. CHAMBERS, *Chairman*

This Committee has again in 1955 been extremely active and has had a tremendous task to perform. As requested by the House of Delegates at its last session in 1955, through the special Reference Committee on Constitution and By-Laws, this Committee has continued to attempt to re-write the entire Constitution and By-Laws in order to make it an instrument more up-to-date and more workable for your Association. The Constitution has not been changed over what was passed in first reading at the 1955 session of the House of Delegates. The By-Laws have been considerably re-written and we earnestly request the study and deliberation of both the Reference Committee and the House of Delegates of these changes. As Chairman, I should like to thank the other members of the Committee, Dr. Thomas Goodwin of Augusta, Dr. William Harbin of Rome, Dr. Eustace A. Allen of Atlanta, and Dr. David Henry Poer of Atlanta. The Committee would also like to express its sincere thanks to the members of the Headquarters Staff, Mr. Milton Krueger and Mr. John Kiser, who have spent many hours editing and re-editing proposed changes in order that they might be grammatically correct and convey the meaning which the Constitution has intended that the wording should convey.

Constitution and By-Laws

Proposed Revision

side over the general meetings of the Association in rotation. The following changes in the MAG Constitution were read and approved *for the first time* on May 3, 1955. These proposed changes will be read for a second time at the 106th Annual Session, May 13-16, 1956, at the Atlanta Biltmore Hotel, Atlanta, Georgia.

Now Reads:

CONSTITUTION

ARTICLE I.

Name of the Association

The name of this organization is The Medical Association of Georgia.

Will Read:

CONSTITUTION

ARTICLE I.

Name of the Association

The name of this organization is The Medical Association of Georgia. It is an Association of its component county medical societies.

Now Reads:

ARTICLE II.

Purposes of the Association

The purposes of the Association shall be to advance the science of medicine; to promote the interests and uphold the honor of the profession of medicine; to acquire, utilize and disseminate information relative to all diseases and degenerative processes affecting mankind to the end that the people of Georgia may have the most adequate medical care possible; to promote public health and to foster cordial relations between the members of the medical profession and the general public.

Will Read:

ARTICLE II.

Purposes of the Association

The purposes of the Association are to promote the science and art of medicine and the betterment of public health.

Now Reads:

ARTICLE III.
Component Societies

Component societies are those county medical societies which hold charters from the Association or which may hereafter be organized and chartered by the House of Delegates of the Association.

Will Read:

ARTICLE III.
Component Societies

Component societies are those county medical societies which hold charters from this Association or which may hereafter be organized and chartered by the House of Delegates of this Association which will form the Medical Association of Georgia.

Now Reads:

ARTICLE IV.
Composition of the Association

SECTION 1. The Association is composed of members and delegates.

SECTION 2. MEMBERS. The members of the Association are the members of the component county medical societies.

SECTION 3. DELEGATES. Delegates are those members elected in accordance with this Constitution and By-Laws to represent their component county medical societies in the House of Delegates of the Association.

Will Read:

ARTICLE IV.
Membership

SECTION 1. MEMBERS. *The members of the Association are the members of the component county medical societies. The Association is composed of Active, Service, Associate and Honorary members as provided for in the By-Laws. Other types of membership may be provided for in the By-Laws.*

SECTION 2. TENURE OF MEMBERSHIP. *A member shall retain his membership as long as he complies with the provisions of the Constitution and By-Laws of this Association and with the Principles of Medical Ethics of the American Medical Association.*

Now Reads:

ARTICLE V.
House of Delegates

SECTION 1. POWERS. The legislative body of the Association is the House of Delegates and it shall transact all business of the Association not otherwise specifically provided for in this Constitution and By-Laws.

SECTION 2. COMPOSITION. The House of Delegates is composed of (1) delegates elected by the component county medical societies, (2) the officers and past presidents of the Association, and (3) the delegates to the American Medical Association.

Will Read:

ARTICLE V.
House of Delegates

SECTION 1. COMPOSITION. *The House of Delegates is composed of Delegates elected by the component county medical societies as provided in the By-Laws. The general officers, the past presidents of the Association, the Treasurer, Editor of the Journal, Delegates to the AMA, the Executive Secretary and Chairmen of Standing Committees shall be ex-officio members of the House of Delegates without the right to vote.*

SECTION 2. DUTIES. *The House of Delegates is the legislative body of the Association, and it shall transact all business of the Association not otherwise specifically provided for in this Constitution and By-Laws.*

Now Reads:

ARTICLE VI.
Council

SECTION 1. The Council shall be the Board of Trustees and the Board of Censors of the Association. It shall carry out the mandates and policies as determined by the House of Delegates. The Council shall have full authority and power of the House of Delegates between sessions of that body.

The Council shall have charge of all the property and financial affairs of the Association and shall perform such duties as are prescribed by law governing directors of corporations or as may be prescribed in the By-Laws.

SECTION 2. The Council shall consist of the President, President-elect, the Immediate Past-President, the Secretary-Treasurer, and one Councilor from each Congressional District in the State of Georgia.

Will Read:

ARTICLE VI.
Council

SECTION 1. COMPOSITION. *The Council is composed of the President, the President-Elect, the Immediate Past President, two Vice-Presidents, the Secretary, the Speaker of the House of Delegates and ten Councilors as provided for in the By-Laws. The Treasurer, Editor of the Journal, Executive Secretary and Delegates to the AMA shall be ex-officio members of Council without the right to vote. Vice-Councilors shall be ex-officio members except in the absence of their respective Councilors as provided for in the By-Laws. The Vice-Speaker shall be an ex-officio member except in the absence of the Speaker as provided in the By-Laws.*

SECTION 2. DUTIES. *The Council is the Board of Trustees and the Board of Censors of the Association. It carries out the mandates and policies as determined by the House of Delegates. The Council has full authority and power of the House of Delegates between sessions of that body. The Council has charge of all property and financial affairs of the Association and performs such duties as are prescribed by law governing directors of corporations or as may be prescribed in the By-Laws.*

Now Reads:

ARTICLE VII.
Sessions and Meetings

SECTION 1. ANNUAL SESSION. The Association shall hold an annual session during which there shall be general meetings open to all registered members, delegates and guests.

SECTION 2. TIME AND PLACE. The time and place for holding each annual session shall be fixed by the Council.

SECTION 3. SPECIAL MEETINGS. Special meetings of either the Association or the House of Delegates may be called by a two-thirds vote of the Council, twenty delegates or upon written petition of one-fourth of the members of the Association.

Will Read:

ARTICLE VII.
Meetings

SECTION 1. ANNUAL SESSION. *The Association shall hold an Annual Session at a time and place fixed by Council.*

SECTION 2. HOUSE OF DELEGATES. *The House of Delegates shall meet during the Annual Session and in interim sessions as may be determined by Council.*

SECTION 3. SPECIAL MEETINGS. *Special meetings of either the Association or the House of Delegates may be called by a two-thirds vote of Council, twenty delegates or upon written petition of one-fourth of the members of the Association.*

Now Reads:

ARTICLE VIII.
District Societies

In order to promote the best interests of the profession, the House of Delegates shall provide for the division of the State into Councilor Districts, which shall be coextensive with the Congressional Districts in Georgia, and for the organization of all component county societies in the districts into Councilor District Medical Societies.

Will Read:

ARTICLE VIII.
District Societies

In order to promote the best interests of the profession, the House of Delegates shall provide for the division of the State into Councilor Districts and for the organization of all component county societies in the districts into Councilor District Medical Societies.

Now Reads:

ARTICLE IX.
Officers

SECTION 1. OFFICERS. The Officers of the Association shall be a President, President-Elect, two Vice-Presidents, Secretary-Treasurer, Speaker of the House of Delegates, Vice-Speaker of the House of Delegates, and one Councilor and a Vice-Councilor from each of the Councilor Districts.

SECTION 2. ELECTION AND ELIGIBILITY. The officers of the Association shall be elected by the members during the annual session. No person shall be eligible to an elective office who has not been a member of the Association for the preceding three years.

SECTION 3. TERMS OF OFFICERS. The President-Elect shall be elected annually. He shall become President on his installation at the close of the next annual session. If the President-Elect be unable to serve, both a President and a President-Elect shall be elected at the appropriate annual session. Other officers shall be elected for terms of one year each, except the Secretary-Treasurer, the Councilors and Vice-Councilors, who shall serve for three years. One-third, or as near as may be, of the Councilors and Vice-Councilors shall be elected annually.

Will Read:

ARTICLE IX.
Officers

SECTION 1. DESIGNATIONS. *The Officers of the Association shall be a President, President-Elect, two Vice-Presidents, the Immediate Past President, the Secretary, the Speaker of the House of Delegates, the Vice-Speaker of the House of Delegates, ten Councilors and ten Vice-Councilors as provided for in the By-Laws.*

SECTION 2. ELECTION AND ELIGIBILITY. *The officers of the Association shall be elected during the Annual Session as provided for in the By-Laws. No member shall serve as an officer who has not been a member of the Association for the preceding three years.*

SECTION 3. TERM OF OFFICE OF PRESIDENT-ELECT. *The President-Elect shall be elected annually and shall become President at the time of the next annual session. If the President-Elect shall be unable to serve, both a President and a President-Elect shall be elected at the appropriate annual session.*

SECTION 4. TERMS OF OTHER OFFICERS. *Other officers shall be elected for terms of one year each except the Secretary, Speaker of the House of Delegates, Vice-Speaker of the House of Delegates, and the Councilors and Vice-Councilors, who shall serve for three years. One-third of the Councilors and Vice-Councilors shall be elected annually. All officers shall serve until their successors are elected and installed.*

SECTION 5. SUCCESSOR TO THE PRESIDENT. *If the President dies, resigns, or is removed from office, the First Vice-President shall immediately become President and shall serve for the remainder of the unexpired term. If the First Vice-President is unable to serve, then the Second Vice-President shall fill the office.*

Now Reads:

ARTICLE X.
Funds and Expenses

Funds for the operation of the Association shall be raised by an equal per capita assessment on the members of each component county medical society. The amount of the assessment shall be set annually by the House of Delegates upon the recommendation of the Council. Funds may also be raised by voluntary contributions, from the Association's publications, and in any other manner approved by the House of Delegates.

The Council shall submit an annual budget for the next succeeding fiscal year to the House of Delegates. This budget shall not exceed the anticipated current income for the period covered by it. The Council shall manage the finances of the Association and shall supervise all funds, investments

and expenditures of the Association. All resolutions providing for appropriations, recommended by the Council, shall be included in the annual budget, subject to final approval of the House of Delegates.

Will Read:

ARTICLE X.
Funds and Expenditures

Funds for the operation of the Association shall be raised by an equal per capita assessment on the members of each component society. The amount of the assessment shall be set by the House of Delegates upon recommendation of Council. Funds may also be raised by voluntary contributions, from the Association's publications, and in any other manner approved by Council. The Council shall submit an annual budget to the House of Delegates and shall manage the finances of the Association.

Now Reads:

ARTICLE XIII.
Amendments

The House of Delegates may amend this Constitution by a two-thirds vote of the Delegates present at any annual session, provided that such amendment shall have been presented to the House of Delegates at the previous annual session and that it shall have been published during the year in The Journal of the Association, or sent officially to each component county society at least two months before the annual session at which final action is to be taken.

Will Read:

ARTICLE XIII.
Amendments

The House of Delegates may amend this Constitution at any session by a two-thirds vote of the Delegates present, provided that the proposed amendment shall have been introduced at the preceding session and provided that the proposed amendment shall have been published during the year in the Journal.

CONSTITUTION

Reference Committee Recommendation—The reference committee considered each item of the Medical Association of Georgia Constitution as approved prior to this date for its first reading on May 3, 1955, and after due consideration recommends unanimously that the Constitution be adopted and read for the second time without change. (The Constitution was then read for the second time before the House of Delegates.)

House of Delegates Action—Recommended adoption of the Constitution of the Medical Association of Georgia at its second reading this date (May 15, 1956) without change, and this recommendation was moved, seconded and adopted.

Now Reads:

BY-LAWS
CHAPTER I.
Membership

SECTION 1. Any physician holding the degree of Doctor of Medicine from a medical college acceptable to the Council of the Association, licensed to practice medicine in the State of Georgia, who has been a citizen of the United States for at least two years and who has not been adjudged guilty of moral turpitude or other serious crime, may be eligible for membership in a component society of the Association.

Will Read:

BY-LAWS
CHAPTER I.
Membership

SECTION 1. A physician holding the degree of Doctor of Medicine or Bachelor of Medicine from a medical college acceptable to the Council of the Association, licensed to practice medicine in the State of Georgia, who has been a citizen of the United States for at least two years and who has not been judged guilty of moral turpitude or other serious crime, may be eligible for membership after being certified by the secretary of a component society as being a member in good standing of said component county society.

Now Reads:

SECTION 3. Membership in the Association shall be classified as active, associate, honorary, life and scientific.

Will Read:

SECTION 3. *Membership in the Association shall be classified as Active, Service, Associate and Honorary.*

Now Reads:

SECTION 4. ACTIVE MEMBERS. All members shall be active, including the right to vote and hold office, unless otherwise classified by action of the component county society.

Will Read:

SECTION 4. ACTIVE MEMBERS. *Physicians who are members in a component county medical society and are eligible to vote and hold office in the society shall be Active members, unless otherwise classified by action of the component county society. These members shall have full privileges of Association membership including the right to hold office and vote, the privilege of Medical Defense and receipt of the Journal of the Medical Association of Georgia, and these members shall pay full dues to the Association annually. New members entering practice after July 1st may pay one-half the annual dues.*

Active members may be excused from the payment of Association dues for one of the following reasons: financial hardship or illness, postgraduate training, defined as that period during which a member participates in an organized training course within a hospital and being retired from active practice, and on temporary service in the Reserve Armed Forces. A member excused from the payment of annual dues for service in the Armed Forces shall not be required to pay annual dues for the period beginning January 1 or July 1 following the date of the member's entrance into service. A member in good standing who is over 70 years of age may also be excused from the payment of Association dues upon his application to the Association through his component county society; this exemption to begin the year following the member's 70th birthday. Active members excused from the payment of Association dues shall have the right to vote and hold office but shall not have the privilege of Medical Defense and shall not receive any publication of the Association except by personal subscription. Nothing in this section shall be construed to be retroactive to affect previously elected Life Members.

Now Reads:

SECTION 5. ASSOCIATE MEMBERS. Any physician who is not engaged in the regular practice of medicine for any one of the following reasons, namely: (1) during organized periods of hospital training and graduate education, (2) during periods of service in the Armed Forces, (3) after retirement, or (4) for whom the payment of dues would constitute a hardship, may be classified by the component county society as an associate member. Associate Members shall be entitled to all the rights and privileges of the Association except that they shall not pay dues or receive The Journal without subscription thereto.

SECTION 6. HONORARY MEMBERS. Eminent physicians and other persons who have distinguished themselves in the science of medicine, or for contributions to human welfare, may be elected to Honorary Membership in the Association by the House of Delegates upon nomination by any component county society and approval of the Committee on Professional Conduct of the Medical Association of Georgia. Such Honorary Members may be issued an appropriate certificate of membership without payment of dues.

SECTION 7. LIFE MEMBERS. A Life Membership may be granted by the House of Delegates, upon the recommendation of the component county society, to any physician who has not had less than forty years of active membership in the Association or has passed his seventieth birthday. He shall not be subject to payment of dues.

SECTION 8. SCIENTIFIC MEMBERS. There shall be created a new division of membership to be known as Scientific Membership. The privileges of membership under this classifica-

tion shall entitle the holder thereof to all phases of the Association's activities pertaining to the study of scientific medicine, and shall include the right to attend all scientific meetings, postgraduate study courses, and scientific sessions of component organizations. Scientific members shall pay no dues and shall not be entitled to vote or hold office. They shall not be entitled to Medical Defense or to receive The Journal except by regular subscription.

SECTION 9. A physician who is under sentence of expulsion from a component county society, or whose name has been dropped from its roll of members, shall not be entitled to any of the rights, privileges or benefits of the Association, nor shall he be permitted to take part in any of its proceedings.

Will Read:

SECTION 5. SERVICE MEMBERS. *Physicians eligible for Service Membership are all full-time commissioned Medical Officers of the Government, in the U. S. Army, Navy, Air Force, United States Public Health Service, Veterans Administration, and Indian Service, and those physicians who have retired from the Services by federal law and who do not engage in active practice. Such members shall not be required to pay the annual dues and shall not be entitled to vote and hold office and shall not have the privilege of Medical Defense, nor shall they receive any publication of the Association except by personal subscription.*

SECTION 6. ASSOCIATE MEMBERS. *Associate membership may be granted to physicians who are engaged in State and County medical services and full-time salaried members of approved medical faculties not engaged in the private practice of medicine provided similar action has been taken by the component county society. Associate membership, except as otherwise provided herein, also may be granted to any member of a component county medical society. Associate members shall pay no dues and shall not be entitled to vote or hold office. They shall not be entitled to the privilege of Medical Defense or to receive any publication of the Association except by personal subscription.*

Will Read:

SECTION 7. HONORARY MEMBERS. *Physicians and persons holding the degree of Doctor of Philosophy who have risen to prominence in their professions may be elected to Honorary Membership by the House of Delegates. Nominations for Honorary Membership may be submitted to the House of Delegates by component county societies or Council. These members shall enjoy all the privileges of the Association but shall not vote or hold office nor shall they receive the privilege of Medical Defense or any publication of the Association except by personal subscription.*

SECTION 8. TENURE. *When the Secretary is officially informed that a member is not in good standing in his component society, he shall remove the name of that member from the membership roll.*

SECTION 9. TRANSFER. *Should a member remove his practice to another jurisdiction he shall apply for a continuance of his membership through the component society in the jurisdiction to which he has moved his practice.*

Now Reads:

SECTION 10. The cause of the failure of a practicing physician to affiliate himself with an available component county society, at any time, shall be ascertained before election to membership.

Will Read:

SECTION 10. *Proposed complete deletion.*

Now Reads:

SECTION 11. Eligible physician members of the State and Federal medical services and full time members of approved medical faculties not engaged in private practice of medicine shall pay half the annual dues of the Association provided similar action has been taken by the component county society.

SECTION 11. *Proposed complete deletion.*

Now Reads:

CHAPTER II.
General Meetings

SECTION 2. The program for the general meetings shall be prepared by the Committee on Scientific Work and approved by the Executive Committee of the Council at least 60 days before the annual session of the Association and published in the issue of The Journal preceding the Annual Session.

SECTION 3. All papers read before the meetings shall become the property of the Association, and shall be deposited with the Secretary-Treasurer immediately after being read. Failure to comply with this and other rules set forth by the Committee on Scientific Work regarding papers, discussions and exhibits shall automatically bar scheduled participation in the scientific sessions in the future from this member for a period of not less than five years unless he presents an acceptable excuse.

SECTION 4. Upon invitation of the President any physician may register at a general meeting of the Association as a guest upon presentation of adequate evidence of membership in good standing in a component unit of the American Medical Association.

Distinguished lay persons and physicians may be invited as special guests of the Association by the President or by action of the Council. Privileges of the floor may be extended to guests at the discretion of the presiding officer.

Will Read:

CHAPTER II.
General Meetings

SECTION 2. *The program for the general meetings shall be prepared by the Council of the Medical Association of Georgia and approved by Council at least sixty days before the annual session of the Association and published in an issue of the Journal preceding the Annual Session.*

SECTION 3. *All papers read before meetings shall be deposited with the Secretary or the presiding officer and shall become the property of the Association. Without an acceptable excuse, failure to comply with this and other rules as regards the Annual Session as set forth by the Council shall automatically prohibit a member from participating in scheduled scientific sessions for a period of not less than five years.*

SECTION 4. *The general meetings shall be open to all registered members. Distinguished lay persons and guest physicians may be invited as special guests of the Association by the President or by action of Council.*

SECTION 5. **LOCAL ARRANGEMENTS COMMITTEE.** *As soon as practicable following the close of each annual session the component society which will act as host at the next annual session shall elect Local Arrangements Committees which shall recommend suitable meeting places and shall have general charge of all local arrangements subject to the approval of Council.*

Now Reads:

CHAPTER III.
House of Delegates

SECTION 1. The House of Delegates shall meet on the first and last day of the annual session at a time fixed by the Council and at such other times as may be necessary for the transaction of the business of the Association.

SECTION 2. Each component county society shall elect one delegate and a corresponding alternate for each twenty-five members, or fraction thereof, whose dues have been paid by December 31st of the preceding year, provided that each component county society shall be entitled to at least one delegate. It shall be the duty of the President to have the representation of each component county society checked by the Committee on Credentials at the time of the annual session, and to fill such vacancies by appointment. Such temporary appointees shall be members of the component society having the vacancy.

SECTION 4. The House of Delegates shall be presided over by the Speaker or, in his absence, by the Vice-Speaker. In

the absence of both, a delegate agreeable to it may preside.

SECTION 5. The Secretary-Treasurer of the Association shall be the Secretary of the House of Delegates or, in his absence, by a delegate appointed by the President. The Executive Secretary may serve in this capacity.

SECTION 6. The following shall be the general Order of Business at all meetings of the House of Delegates: 1. Call to Order by the President; 2. Roll Call; 3. Election of Speaker and Speaker pro tem; 4. Reading and adoption of minutes; 5. Reports of officers; 6. Reports of committees; 7. Unfinished business; 8. New business.

SECTION 7. For the purpose of expediting proceedings the President shall appoint from the members of the House of Delegates the Reference Committees and other committees considered necessary. Any member of the Association may be appointed to serve on a committee created for a special purpose. Such members who are not members of the House of Delegates shall have the right to present their reports in person and to participate in the debate, but shall not have the right to vote.

Will Read:

CHAPTER III.
House of Delegates

SECTION 1. **MEETINGS.** *The House of Delegates shall meet during the Annual Session at a time and place fixed by Council. The House of Delegates may also meet in interim sessions and at such other times as may be necessary for the transaction of the business of the Association.*

SECTION 2. Each component county society shall elect one delegate and a corresponding alternate, each of whom has been a member in good standing for the prior three years, for each 25 members, or fraction thereof, whose dues have been paid by December 31st of the preceding year, provided that each component county society shall be entitled to at least one delegate. Delegates to the House of Delegates shall serve for a term of three years; one-third of the members of the House of Delegates to be elected annually provided that the component county societies which are entitled to three or more delegates shall elect at their first election one-third of their delegation for a term of one year, one-third of their delegation for a term of two years, and one-third of their delegation for a term of three years and thereafter elect such delegates whose terms of office expire therewith. Those component county societies which are entitled to less than three delegates shall elect their delegate or delegates for staggered terms in rotation as may be determined by Council until one-third of the House of Delegates is being elected annually.

SECTION 4. *The House of Delegates shall be presided over by the Speaker or, in his absence, by the Vice-Speaker. In the absence of both, a delegate agreeable to it may preside. The Speaker and the Vice-Speaker shall be elected by the members of the House of Delegates and shall serve for a term of three years.*

SECTION 5. *The Secretary of the Association shall be the Secretary of the House of Delegates or, in his absence, a Delegate appointed by the Speaker of the House of Delegates shall serve as Secretary of the House of Delegates. The Executive Secretary may serve in this capacity.*

SECTION 6. *The following shall be the general Order of Business at all meetings of the House of Delegates: 1. Call to order by the Speaker; 2. Roll Call; 3. Election of Speaker and Vice-Speaker (every third year at second session of House of Delegates during Annual Session; their terms of office to begin with adjournment of the House of Delegates; provided a Speaker and Vice-Speaker be elected as the next order of business after the adoption of this by-law); 4. Reading and adoption of minutes; 5. Reports of officers; 6. Reports of committees. 7. Unfinished business. 8. New business.*

At any meeting, the House by majority vote may change the Order of Business. New Business may be introduced at the final meeting of the House of Delegates only when such

business is of an emergency nature or introduced by unanimous consent.

SECTION 7. *For the purpose of expediting proceedings, the Speaker of the House of Delegates shall appoint from members of the House of Delegates the reference committees, the credentials committee, and other committees considered necessary. Any member of the Association may be appointed to serve on a committee created for a special purpose. Such members who are not members of the House of Delegates shall have the right to present their reports in person and to participate in debate, but shall not have the right to vote.*

Now Reads:

SECTION 9. The House of Delegates shall nominate members of all Boards required by the Laws of Georgia.

Will Read:

SECTION 9. *Proposed complete deletion.*

Now Reads:

CHAPTER IV.
Council

SECTION 1. The Council shall meet on the last day of the annual session of the Association to organize and at intervals of not more than four months apart until the next annual session. Special meetings of the Council may be held on the call of the President or upon request of three members of the Council.

SECTION 2. The Council shall be composed of the President, the President-Elect, Vice-Presidents, Secretary-Treasurer, and one Councilor or Vice-Councilor from each Councilor district. Each Councilor and Vice-Councilor shall be nominated by each district society at the time of its annual meeting. In the event of a vacancy in the office of a Councilor and Vice-Councilor, the vacancy may be filled temporarily by appointment by the President from members of that district society.

SECTION 3. The Council shall set up an Executive Committee composed of the President, Secretary-Treasurer, Chairman of the Council and two other members of the Council. The President shall be the chairman of the Executive Committee. It shall meet not less often than bi-monthly to review the affairs of the Association. The Committee shall make recommendations to the Council and shall carry out such items of business as are referred to it by the Council.

SECTION 4. The Chairman of the Council shall be elected annually at the organization meeting and shall serve one year, or until his successor is elected. He shall preside over its meetings and appoint all necessary committees. A Vice-Chairman shall be elected from among its members. The Secretary-Treasurer of the Association shall be the Secretary of the Council.

SECTION 5. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the powers conferred on the House of Delegates by the Constitution and By-Laws.

SECTION 6. The Council shall be the Board of Censors of the Association. It shall consider all questions involving the right and standing of members, whether in relation to other members, to the component societies or to the Association. Any question of an ethical nature may be brought before the Council by the Committee on Professional Conduct or by any member of the Association. It shall hear and decide all questions of discipline affecting the conduct of members of component societies, on which an appeal is taken from the decision of a component society. Its decision in all cases, including questions regarding membership in the Association, shall be final subject to approval of the House of Delegates.

SECTION 7. Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of, and to aid in, the betterment of the component societies in his district. He shall make an annual report of

his work, listing all eligible physicians in his district who are not members of a component society and of the condition of the profession of each county in his district at the annual session of the House of Delegates. The Vice-Councilor shall assist the Councilor in the performance of his duties. He becomes a voting member of the Council only in the absence of the Councilor from his district.

SECTION 8. Charters for county and district societies shall be issued on approval of the Council and shall be signed by the President and Secretary-Treasurer of the Association. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

SECTION 8. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designated so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all the rights and privileges provided for component societies until such counties shall be organized separately. A physician residing in a county not having a component society shall be referred to an adjacent component county society by the Council for consideration for membership. Choice of any other component county society by such a physician for membership shall be made only with the full consent of all component societies involved.

SECTION 10. The Council shall provide for and superintend the issuance of all necessary publications of the Association, including proceedings, transactions and memoirs.

SECTION 11. The Chairman of the Council shall appoint from among its members, a committee of three members to be known as the Committee on Auditing and Appropriations, which shall cause to be audited all accounts of the Association. The Council shall propose an annual budget for the fiscal year beginning January 1 after each annual session. This proposed budget shall be prepared by the Committee on Auditing and Appropriations for the consideration of the Council at the last meeting in the last quarter of each year. This budget shall be presented to the House of Delegates for its approval after which it becomes effective. It shall also submit an annual report to the House of Delegates, which shall specify the character of all of its property and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

SECTION 12. The Council shall authorize the payment of all necessary expenses incurred by the officers of the Association in the performance of their duties, except those incurred during the annual session. The Council also may authorize a special fund to be made available to the President of the Association, who may expend all or any part of it for the good of the Association without restriction.

SECTION 13. The Council shall appoint, at least six months before the annual session, a committee, consisting of three or more of its members, to be known as the Committee on Arrangements for the annual session. This committee shall appoint a general chairman of a local committee on arrangements, who shall be a member of the component society in which the annual session is to be held. This local Chairman shall appoint, from the members of his county society, the personnel of the local committee on arrangements. The local committee on arrangements shall provide suitable meeting places and shall have general charge of all local arrangements subject to the approval of the Committee on Arrangements for the annual session. All expenditures made by that committee in connection with the annual session must be authorized in advance by the Committee on Auditing and Appropriations of the Council. Immediately after the annual session the Committee on Arrangements of the Council shall forward to the Secretary-Treasurer any accumulated balance. Auditing and Appropriations.

SECTION 14. The Council shall by apointment fill any vacancy in office not otherwise provided for which may occur during the interval between anual sessions of the Association. The appointee shall serve until his successor has been elected and installed.

SECTION 15. The Council may appoint an Assistant Secretary-Treasurer or an Executive Secretary—either or both—and fix their terms of employment.

SECTION 16. The Council shall determine the employment and salaries of all personnel necessary to conduct the affairs of the Association subject to approval of the House of Delegates.

SECTION 17. The Council shall provide such headquarters for the Association as may be required to conduct its affairs.

SECTION 18. The Council shall have control of all technical exhibits at the annual session.

SECTION 19. The Council shall fix the bond of the Secretary-Treasurer and all other necessary personnel of the Association.

SECTION 20. The Council shall have full and complete charge of all public relations of the Association, subject only to the House of Delegates.

Will Read:

**CHAPTER IV.
Council**

SECTION 1. COMPOSITION. *The Council is composed of the President, the President-Elect, the Immediate Past President, two Vice-Presidents, the Secretary, Speaker of the House of Delegates or the Vice-Speaker of the House of Delegates and one Councilor or Vice-Councilor from each Councilor District. Vice-Councilors shall be ex-officio members of Council, without the right to vote, except in the absence of their respective Councilors when they shall serve as Councilor. The Vice-Speaker shall be an ex-officio member of Council without the right to vote except in the absence of the Speaker when he shall serve in the Speaker's stead. The Treasurer, Editor of the Journal, Executive Secretary, and Delegates to the AMA shall be ex-officio members of Council without the right to vote.*

SECTION 2. CHAIRMAN AND SECRETARY. *A Chairman and a Vice-Chairman of Council shall be elected annually at the organizational meeting and shall serve for one year, or until their successors are elected. The Chairman or Vice-Chairman shall preside over meetings of Council and appoint all necessary committees of Council. The Secretary of the Association shall serve as Secretary of Council. The Council may designate the Executive Secretary or Assistant Executive Secretary to serve in this capacity.*

SECTION 3. EXECUTIVE COMMITTEE. *The Council shall organize an Executive Committee at the organizational meeting. The Executive Committee shall be composed of the President, the President-Elect, the Immediate Past President, the Secretary, the Chairman of Council, who shall serve as presiding officer, and the Chairman of the Council Committee on Finance. It shall meet monthly between the meetings of Council. The Committee shall make such recommendations to the Council and shall carry out such items of business as are referred to it by Council. The Executive Committee shall appoint all committee chairmen and committees of the Association and nominate members of all Boards required by the laws of the State of Georgia on recommendation of the District Societies where applicable; not otherwise provided for, subject to confirmation by Council, and shall serve as Publications Committee of the Journal. The Executive Committee shall recommend to Council the terms of employment and salaries of all personnel necessary to conduct the affairs of the Association. The Executive Committee shall be empowered to select an Executive Secretary who shall be responsible to the Executive Committee for his action and for the operation of the Headquarters Office, subject to the approval of Council. The Executive Committee shall act as a Board of Trustees directing the Executive*

Secretary in carrying out the mandates and policies of the Council and the House of Delegates.

SECTION 4. MEETINGS. *The Council shall meet at the close of the annual session to organize and at intervals of not more than four months until the next annual session. Special meetings of Council may be held on the call of the President or upon the request of three members of Council. Regular meetings of Council will be held on call of the Chairman.*

SECTION 5. GENERAL DUTIES. *The Council shall be the executive body of the House of Delegates and between sessions shall exercise the powers conferred on the House of Delegates by the Constitution and By-Laws. The Council shall provide such headquarters for the Association as may be required to conduct its affairs. The Council shall by appointment fill any vacancy in office not otherwise provided for, which may occur during the interval between Annual Sessions of the Association. The appointee shall serve until his successor has been elected and installed.*

The Council shall authorize the payment of all necessary expenses incurred by the officers of the Association in the performance of their duties, except those incurred during the annual session. The Council, also, may authorize a special fund to be made available to the President of the Association, who may expend all or any part of it without restriction for the good of the Association.

SECTION 6. SPECIFIC DUTIES. *The Council shall determine the employment and salaries of all personnel necessary to conduct the affairs of the Association on the recommendation of the Executive Committee of Council. The Council shall control and direct all Association publications.*

SECTION 7. BOARD OF CENSORS. *The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standing of members whether in relation to other members, to the component societies or to the Association referred to it by the Association's Professional Conduct Committee. Any question of an ethical nature may be brought before the Council by the Committee on Professional Conduct or by any member of the Association or upon the request of the party concerned on which an appeal is taken from the decision of the Association's Professional Conduct Committee. It shall hear and decide all questions of discipline affecting the conduct of members of component societies, on which an appeal is taken from the decision of a component society or the Association's Professional Conduct Committee. Its decision in all cases, including questions regarding membership in the Association, shall be final subject to approval of the House of Delegates.*

SECTION 8. COUNCILOR AND VICE-COUNCILOR DUTIES. *Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of, and to aid in the betterment of, the component societies in his district. He shall make an annual report of his work, listing all eligible physicians in his district who are not members of a component society and of the condition of the profession of each county in his district at the annual session of the House of Delegates. The Vice-Councilor shall assist the Councilor in the performance of his duties. He becomes a voting member of the Council only in the absence of the Councilor from his district.*

SECTION 9. COMMITTEE ON FINANCE. *The Chairman of the Council shall appoint from among its members a committee of three members to be known as the Committee on Finance, which shall cause to be audited all accounts of the Association. The Council shall propose an annual budget for the fiscal year beginning January 1st after each annual session. This proposed budget shall be prepared by the Committee on Finance for the consideration of the Council*

at the last meeting in the last quarter of each year. This budget shall be presented to the House of Delegates for its approval. It shall also submit an annual report to the House of Delegates, which shall specify the character of all of its property and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

All expenditures made by the Local Arrangements Committee in connection with the annual session must be authorized in advance by the Committee on Finance. Council shall have control of all commercial exhibits at the Annual Sessions and any deficit created on account of the annual session shall be met by Council on recommendation of the Committee on Finance.

SECTION 10. *Proposed complete deletion.*

SECTION 11. *Proposed complete deletion.*

SECTION 12. *Proposed complete deletion.*

SECTION 13. *Proposed complete deletion.*

SECTION 14. *Proposed complete deletion.*

SECTION 15. *Proposed complete deletion.*

SECTION 16. *Proposed complete deletion.*

SECTION 17. *Proposed complete deletion.*

SECTION 18. *Proposed complete deletion.*

SECTION 19. *Proposed complete deletion.*

SECTION 20. *Proposed complete deletion.*

Now Reads:

CHAPTER V. Election of Officers

SECTION 1. The President-Elect, Vice-Presidents, Secretary-Treasurer, Councilors and Vice-Councilors shall be elected by ballot by the members of the Association. Nominations for these officers except Councilors and Vice-Councilors shall be made orally as the last order of business at the first meeting on the first day of the scientific session. No nominating or seconding speech shall exceed two minutes. The President shall appoint a Committee of not less than three Tellers immediately after the close of nominations who shall have charge of the election.

SECTION 2. Nominations for Councilors and Vice-Councilors shall be made by each district society at its annual meeting and forwarded by its secretary to the secretary of the Association not later than 15 days before the annual session. If no nomination is presented by a district society in this manner, nominations for Councilor and Vice-Councilor from each district shall be made from the floor. One-third of the Councilors and Vice-Councilors shall be elected annually.

SECTION 3. The Secretary-Treasurer shall have prepared in advance an official ballot. One ballot shall be given to each active voting member when he presents himself to cast his ballot. Such member and no other shall prepare his ballot and shall deposit it at that time in a locked ballot box provided by the Secretary-Treasurer and kept in the custody of the Tellers designated by the President. The key shall be kept by the Chairman of the Tellers.

SECTION 4. Voting shall take place during the hours of the scientific program up to 10:30 a.m. of the last day of the annual session. At that time the Committee of Tellers appointed by the President shall count the ballots and report their findings to the members at the last meeting of the Association. The candidate for President-Elect receiving a majority of the votes shall be declared elected, but if no majority is received on the first ballot, the members present shall select the President-Elect from the two candidates having the highest number of votes by secret ballot. Other officers shall be elected by receiving the highest number of votes on the first ballot.

Will Read:

CHAPTER V. Election of Officers

SECTION 1. ELECTION. *The President-Elect, two Vice-Presidents, Secretary, Councilors and Vice-Councilors shall be*

elected by ballot by the members of the Association during the Annual Session. The President-Elect shall be elected annually and shall become President at the time of the next annual session. The Speaker of the House of Delegates and Vice-Speaker of the House of Delegates shall be elected by members of the House of Delegates and shall serve for a term of three years. Other officers shall be elected for terms of one year each except the Secretary, Councilors and Vice-Councilors who shall serve for three years. One-third of the Councilors and Vice-Councilors shall be elected annually.

SECTION 2. NOMINATIONS. *Nominations for these officers except the Speaker and Vice-Speaker and the Councilors and Vice-Councilors shall be made orally from the floor as the last order of business at the first general session of the annual session and no nominating or seconding speech shall exceed two minutes. Nominations for Speaker and Vice-Speaker shall be made by members of the House of Delegates orally on the floor of the House of Delegates as provided in the House of Delegates order of business. Nominations for Councilors and Vice-Councilors shall be made by each district society at its annual meeting and forwarded by its secretary to the Secretary of the Association not later than 15 days before the annual session. If no nomination is presented by a district society in this manner, nominations shall be made from the floor.*

SECTION 3. METHOD. *The President shall appoint a committee of not less than three Tellers immediately after the close of nominations, who shall have charge of the election. The Secretary shall have prepared in advance an official ballot and an official ballot box, which shall be kept in the custody of the Tellers Committee. One ballot only shall be given to each active voting member when he presents himself to cast his ballot. Such member and no other shall prepare his ballot and shall deposit it at that time in the locked ballot box.*

The candidates for office receiving a majority of the votes shall be declared elected, but if no majority is received on the first ballot, the members present shall select by secret ballot the officer from the two candidates having the highest number of votes.

SECTION 4. TIME. *Voting shall take place during the hours of the scientific program up to the beginning of the last meeting on the last day of the annual session. At that time the Committee of Tellers shall count the ballots and report their findings to the members.*

Now Reads:

CHAPTER VI. Duties of Officers

SECTION 1. THE PRESIDENT. The President shall preside at the organization meeting of the House of Delegates and at all meetings of the Association and shall appoint all committees not otherwise provided for. He shall deliver an address at such time during the annual session as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession and of the Association in the State during his term of office. So far as practicable he shall visit by appointment the various district societies, and shall assist the Councilors in building up the county societies, and in increasing the prestige of the Association. He shall be a member of the Council and its Executive Committee, and shall be a member of all committees of the Association with the authority to call a meeting of any committee when necessity demands it or after failure of the chairman to do so. With the consent of the Council he shall terminate any committee whose function has been fulfilled. It shall be his duty with the approval of the Council, to replace any member of any committee who fails to show interest in performing the duties assigned him.

SECTION 2. THE PRESIDENT-ELECT. The President-Elect shall be a member of the Council, and shall be a member

ex-officio of all standing committees. In order to acquaint himself with all the activities of the Association, it shall be his duty to attend all meetings of the Council and the Standing Committees.

SECTION 3. THE VICE-PRESIDENTS. The Vice-Presidents shall assist the President in the discharge of his duties. Upon request or in the absence of the President, the Vice-Presidents will preside over the general meetings of the Association in rotation. In the event of the President's death, resignation, or inability to serve, the Vice-Presidents, in their order shall succeed him for the unexpired term.

SECTION 4. THE SECRETARY-TREASURER. (A) The Secretary-Treasurer or his representative shall attend the general meetings of the Association and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings in separate record books. He shall be Secretary of the Council and its Executive Committee and an ex-officio member of all committees.

SECTION 4. (B) He shall be custodian of all record books and papers belonging to the Association and shall keep account of all funds of the Association which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall with the cooperation of the secretaries of the component societies, keep a card-index register of all the legal practitioners of the State by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ assistants as may be ordered by the Council and shall supply all component societies with the necessary blanks for making their annual reports, and shall collect the regular per capita assessments from the component societies. The amount of his salary shall be fixed by the Council.

SECTION 4. (C) He shall give bond in the amount of a sum to be fixed by the Council. He shall receive all funds of the Association, together with bequests and donations. He shall pay money out of the treasury only on authorization of the Council; he shall furnish a balance sheet to the Council at the last meeting of the fiscal year at the annual session of the Association. This shall consist of an itemized statement of all financial transactions of the past year, all accounts made, money received and disbursed with vouchers attached. The fiscal year includes the period of time between January 1st and December 31st. This financial report shall be published in The Journal as soon as practicable after the end of each fiscal year.

Will Read:

CHAPTER VI.

Rights and Duties of Officers

SECTION 1. PRESIDENT. *The President shall (A) preside at all general meetings of the Association; (B) address the opening General Session of the annual session; (C) assist the Councilors in improving the county and district societies as far as practicable; (D) serve as a member of Council and as a member of the Executive Committee; (E) serve as a member of all committees of the Association with the authority to call a meeting of any committee when necessity demands it or after failure of the chairman to do so. With the approval of Council, he may terminate any committee whose function has been fulfilled or replace any member of any committee who fails to show interest in performing the duties assigned to him; (F) he shall be an ex-officio member of the House of Delegates without the right to vote.*

SECTION 2. PRESIDENT-ELECT. *The President-Elect shall be a member of the Council and of its Executive Committee, and shall be a member ex-officio without the right to vote,*

of all Standing Committees. In order to acquaint himself with all the activities of the Association, it shall be his duty to attend all meetings of the Council and, when possible, the Standing Committees. He shall be an ex-officio member of the House of Delegates without the right to vote.

SECTION 3. THE VICE-PRESIDENTS. *The Vice-Presidents shall be members of the Council. The Vice-Presidents shall assist the President in the discharge of his duties. Upon request or in the absence of the President, the Vice-Presidents will preside over the general meetings of the Association in rotation. In the event of the President's death, resignation, or inability to serve, the Vice-Presidents, in their order shall succeed him for the unexpired term. The Vice-Presidents shall be ex-officio members of the House of Delegates without the right to vote.*

SECTION 4. SECRETARY. (A) *The Secretary and the Executive Secretary shall attend the general meetings of the Association and the meetings of the House of Delegates. The Secretary shall keep the minutes of their respective proceedings. At the request of the Secretary, the Executive Secretary may serve in this capacity. The Secretary, or upon his request, the Executive Secretary, shall be Secretary of the Council and its Executive Committee. The Secretary shall be an ex-officio member, without the right to vote, of the House of Delegates and all committees of the Association.*

SECTION 4. (B) *The Secretary and/or Executive Secretary, under the direction of the Executive Committee of Council, shall be custodian of all Association record books and papers, conduct the official correspondence of the Association, maintain membership records, issue membership cards and provide for the registration of members at annual sessions.*

The Secretary shall collect the regular per capita assessment from the component societies and shall make all required reports to the American Medical Association.

SECTION 4. (C) *Proposed Complete Deletion.*

SECTION 5. IMMEDIATE PAST PRESIDENT. *The Immediate Past President shall serve for one year immediately following his term of office as President. He shall serve on the Council and its Executive Committee and shall be an ex-officio member of the House of Delegates without the right to vote.*

SECTION 6. SPEAKER. *The Speaker of the House of Delegates shall serve for three years after being duly elected by the members of the House of Delegates and he shall preside over all meetings of the House of Delegates. He shall also serve as a member of the Council concurrent with his term of office. It shall be his duty to preserve order and to follow the proper parliamentary procedures. It shall be the duty of the Speaker to have the representation of each component county society checked by the Committee on Credentials at the time of the Annual Session, and to fill such vacancies by appointment. Such temporary appointees shall be members of the component society having the vacancy. He shall appoint the House of Delegates Reference Committees and Credentials Committee.*

SECTION 7. VICE-SPEAKER. *The Vice-Speaker of the House of Delegates shall serve for three years after being duly elected by the members of the House of Delegates and he shall preside over the House of Delegates in the absence of the Speaker. The Vice-Speaker shall be an ex-officio member of the Council without the right to vote except in the absence of the Speaker when he shall serve in the Speaker's stead. In the event of the Speaker's death, resignation or inability to serve, the Vice-Speaker shall succeed him for the unexpired term.*

Now Reads:

CHAPTER VII.

Component County Societies and District Societies

SECTION 1. COUNTY AND DISTRICT SOCIETIES. *All county and district societies now in affiliation with the Medical Association of Georgia or those hereafter organized in this state*

which have adopted principles of organization in conformity with this Constitution and By-Laws may receive charters from the Association, provided that their constitution and by-laws shall have been submitted to the Council and received its approval. A component society shall consist of three or more active members.

SECTION 2. CHARTER. Upon application to and recommendation by the Council, the House of Delegates shall provide and issue charters to county and district medical societies organized to conform to this Constitution and By-Laws. Such charters shall be signed by the President and the Secretary-Treasurer. The House of Delegates shall have authority to revoke the charter of any component county society or district society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws. Only one component county society shall be chartered in each county.

SECTION 3. NAMES OF SOCIETIES. The name and title of each component county society and district society shall read exactly as found in its charter. No change in such name shall be made without the approval of the Council of the Medical Association of Georgia.

SECTION 4. CUSTODY OF CHARTER. The charter of each component county society and district society as issued by The Medical Association of Georgia, shall be preserved and shall be in the custody of the secretary of such society at all times.

SECTION 5. CONSTITUTION AND BY-LAWS. Each component county society and district society shall have a constitution and by-laws. These shall be in conformity with the Constitution and By-Laws of The Medical Association of Georgia, and a copy thereof shall be transmitted to the headquarters of The Medical Association of Georgia for approval and record.

SECTION 6. PURPOSES AND DUTIES. Each component county society shall have general direction of the affairs of the profession in the county and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of its members. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SECTION 7. OFFICIAL RECORDS. The official copy of the constitution and by-laws of each component county society shall be kept in a special book provided for that purpose. In it shall be entered all amendments which have been notified by the Council of The Medical Association of Georgia. It shall contain the signature of each member who is entitled to membership in The Medical Association of Georgia, together with the date of his election, decease, resignation or expulsion. It shall be the duty of the secretary to preserve this book and hold it available when required for reference.

SECTION 8. DELEGATES AND ALTERNATES. Each component county society at its annual meeting shall elect delegates and alternates to represent it in the House of Delegates of the Association in accordance with these By-Laws, unless other definite procedure for the selection of delegates is provided in its constitution and by-laws. The secretary of each component county society shall send a list of such delegates to the Secretary-Treasurer of the Association at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with these provisions. In the absence of, or the disability or disqualification of a delegate, the vacancy shall be filled by the President from other members of the same component county society.

SECTION 9. COMBINED COUNTIES. The House of Delegates shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district or other classes of societies. Such societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for component county societies.

SECTION 10. ANNUAL MEETING. Each component county society shall designate the meeting held nearest January 1st of each year as its annual meeting, at which time delegates to the House of Delegates, and a local member of the sub-committee on Legislation and sub-committee on Public Health will be chosen, and their names forwarded promptly to the Secretary of the Association.

SECTION 11. PURPOSES AND DUTIES OF DISTRICT SOCIETIES. District Societies shall have one or more meetings during the year. A Councilor and a Vice-Councilor shall be nominated at the appropriate annual meeting and forwarded to the Secretary of the Association to be elected by the Association for terms of three years in a rotating manner with other district societies. At the same time, each shall elect a member to the sub-committees on Legislation and Public Health of the Association.

Will Read:

CHAPTER VII.

Component County Societies

SECTION 1. COUNTY SOCIETIES. *All county societies now in affiliation with the Medical Association of Georgia or those hereafter organized in this state which have adopted principles of organization in conformity with this Constitution and By-Laws may receive charters from the Association, provided that their constitution and by-laws shall have been submitted to the Council and received its approval in this regard. A component society shall consist of three or more active members.*

SECTION 2. CHARTER. *Council shall provide and issue charters to county medical societies organized to conform to this Constitution and By-Laws. Such charters shall be signed by the President and the Secretary. The House of Delegates shall have authority to revoke the charter of any component county society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws. Only one component county society shall be chartered in each county.*

SECTION 3. NAMES OF SOCIETIES *The name and title of each component county society shall read exactly as found in its charter. No change in such name shall be made without the approval of the Council of the Medical Association of Georgia.*

SECTION 4. CUSTODY OF CHARTER. *The charter of each component county society as issued by the Medical Association of Georgia, shall be preserved and shall be in the custody of the Secretary of such society at all times.*

SECTION 5. PURPOSES. *Each component county society shall promote the science and art of medicine and the betterment of public health in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of its members. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every acceptable and eligible physician in the county or counties in its jurisdiction.*

SECTION 6. DUTIES. *Each component county society shall meet the following five minimum standards: Each society shall (1) meet a minimum of four times a year, elect officers and delegates annually at a meeting before January 1st and report these officers to the headquarters office before January 1st; (2) maintain an up-to-date constitution and by-laws in conformity with the Constitution and By-Laws of the Medical Association of Georgia and shall transmit a copy of its constitution and by-laws to the headquarters office for record; (3) maintain a Board of Censors and/or a Mediation Committee; (4) maintain minutes of each meeting in a permanent record book that will be available at all times; (5) maintain scheduled programs at its minimum four meetings annually.*

SECTION 7. DELEGATES. *Each component county society shall elect at its annual meeting prior to January 1st Delegates and Alternates to the House of Delegates in accordance with these By-Laws. The secretary of each component society shall send a list of such delegates to the Secretary of the Association before January 15th. In the absence of, or*

the disability or disqualification of a delegate, the vacancy may be filled by the President of the society from other members of the same component society, provided such vacancy is filled prior to the first session of the House of Delegates.

SECTION 8. COMBINED COUNTIES. *In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designated so as to distinguish them from district societies. These societies when chartered shall be entitled to all the rights and privileges provided for component societies. A physician residing in a county not having a component society shall be referred to an adjacent component county society by Council.*

SECTION 9. ANNUAL MEETING. *Each component county society shall designate a meeting held prior to January 1st as its annual meeting at which time officers and delegates for the next year shall be elected and their names forwarded before January 15 to the Secretary of the Association.*

SECTION 10. DISTRICT SOCIETIES. *District societies shall have one or more meetings during the year and shall nominate a Councilor and Vice-Councilor as provided in these By-Laws. These district societies shall be organized for the best interests of the medical profession in Georgia and shall not necessarily conform with the boundaries of congressional districts. District societies shall elect officers, adopt a constitution and by-laws in conformity with the Constitution and By-Laws of the Medical Association of Georgia and levy dues for the government of its own affairs.*

SECTION 11. *Proposed complete deletion.*

Now Reads:

CHAPTER VIII.

Dues and Assessments

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates upon recommendation of the Council and shall be levied per capita on the members of the Association. They shall be payable on or before January 1st of the year for which they are levied. The secretary of each component county society shall cause to be collected and shall forward to the office of the Association the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the Secretary-Treasurer of the Association on or before April 1st, shall stand suspended until his name is properly reported and his dues for the current year properly remitted. At no time and under no circumstances shall a member make payment of dues or assessments directly to the Secretary-Treasurer of the Association. Neither shall the Secretary-Treasurer of the Association receive payments of dues or assessments from anyone except the secretary of the component county society or his representative.

An active member who fails to pay dues for one or more years current year plus one year's dues in arrears subject to reapplication and approval by his county society.

SECTION 2. The record of payment of dues and assessments on file in the office of the Association shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Association and of the House of Delegates.

SECTION 3. For the purpose of medical defense, a member shall be deemed in arrears from and during the period extending April 1st of the current year until his dues and assessments shall have been received at the office of the Association, having been remitted by the secretary of the component county society of which he is a member.

SECTION 4. Any county society which fails to make the reports required before the annual session of the Association, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Association or of the House of Delegates.

Will Read:

CHAPTER VIII.

Funds and Expenditures

SECTION 1. TREASURER. *The Treasurer shall be appointed annually by the Executive Committee of Council subject to the approval of Council. The Treasurer shall be a member in good standing for at least three years prior to his appointment and may be the same person as the Secretary. The Treasurer shall not be an officer of the Association but shall be an ex-officio member, without the right to vote, of Council and the House of Delegates. He shall be an ex-officio member, without the right to vote, of the Committee on Finance. The Treasurer shall give bond in such sum as may be fixed by the Council the premium on such bond to be paid by the Association.*

SECTION 2. TREASURER'S DUTIES. *The Treasurer shall receive all funds of the Association together with bequests and donations. He shall pay money out of the treasury only on authorization of the Council; he shall furnish a balance sheet to the Council at its last meeting of the fiscal year. The fiscal year includes the period of time from January 1st to December 31st inclusive. A financial report shall be published in the Journal as soon as practicable after the end of each fiscal year. All checks for Association expenditures shall be signed by both the Treasurer and the Secretary, or by any two officers of the Association designated by Council.*

SECTION 3. DUES AND ASSESSMENTS. (A) *The annual dues and assessments shall be determined by the House of Delegates upon recommendation of the Council and shall be levied per capita on the active members of the Association. They shall be payable on or before January 1st of the year for which they are levied. The secretary of each component county society shall cause to be collected and shall forward to the office of the Association before January 1st the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the headquarters office of the Association on or before April 1 shall stand suspended until his name is properly reported and his dues for the current year properly remitted. At no time and under no circumstances shall a member make payment of dues or assessments directly to the headquarters office of the Association. Neither shall the headquarters office of the Association receive payments of dues or assessments from anyone except the secretary of the component county society or his representative.*

An active member who fails to pay dues for one or more years shall be eligible for reinstatement upon payment of dues for the current year plus one year's dues in arrears subject to reapplication and approval by his county society.

SECTION 3. (B) *The record of payment of dues and assessments on file in the office of the Association shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Association and of the House of Delegates.*

SECTION 3. (C) *For the purpose of medical defense a member shall be deemed in arrears from and during the period extending April 1st of the current year until his dues and assessments shall have been received at the office of the Association, having been remitted by the secretary of the component county society of which he is a member.*

SECTION 3. (D) *Any county society which fails to make the reports required before the annual session of the Association shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Association or of the House of Delegates.*

Now Reads:

CHAPTER IX.

Standing Committees

SECTION 1. The Standing Committees of the Association shall be as follows:

A) Committee on Scientific Work

- B) Committee on Legislation
- C) Committee on Medical Education
- D) Committee on Medical Defense
- E) Committee on Professional Conduct
- F) Committee on History and Vital Statistics
- G) Committee on Public Health
- H) Committee on Maternal and Infant Welfare
- I) Committee on Rural Health
- J) Committee on Industrial Health
- K) Committee on Public Relations
- L) Committee on Cancer
- M) Committee on Insurance
- N) Committee on Veterans Affairs
- O) Committee on Constitution and By-Laws
- P) Committee on Awards
- Q) Committee on Woman's Auxiliary
- R) Committee on Hospitals

SECTION 2. Unless otherwise provided in these By-Laws, each of these committees shall consist of three members, each of whom shall serve for three years. One member of each standing committee shall be appointed each year by the President to serve for three or more years as required by each committee and announced at the time of the final meeting of the Association each year. Provided that for the first year the President shall appoint three or more members as required with one member to serve for the necessary graduated period of years to meet these requirements. Failure of a member to carry out the duties of his committee assignment during any year shall automatically cause his removal at the time of the annual session and the President, with the consent of the Council, shall appoint another member to fill his unexpired term. All committees shall make an annual report in writing to the Association headquarters office sixty days in advance of the Annual Session.

A) THE COMMITTEE ON SCIENTIFIC WORK. The Committee on Scientific Work shall be composed of five members: the President, the Secretary-Treasurer and three members appointed for terms of three years each. The senior appointed member shall serve as chairman. The duties of the Committee on Scientific Work shall be to prepare and publish the Scientific Program of the annual session, subject to the approval of Council. It shall also prepare and publish all rules and regulations governing the selection and presentation of papers, discussions and Scientific Exhibits before the general meetings and shall present them for publication in The Journal of the Association.

The presentation of Scientific Exhibits for the annual session shall be under the direction of this committee. For this purpose, the committee may set up a sub-committee of three or more members with representatives from the two medical schools of the State.

All lectureships of the Association shall be under the control of this committee, but special sub-committees may be established to advise the committee concerning the selection of proper speakers for each lectureship. These special lectures shall be given before the general meetings at a time selected by the Committee on Scientific Work.

B) THE COMMITTEE ON LEGISLATION. The duties of the Committee on Legislation shall be to represent the Association in securing and enforcing legislation in the interests of public health and of scientific medicine. It shall keep in touch with professional and public opinion, shall endeavor to shape legislation so as to secure the best results for the whole people, and shall strive to organize professional influence so as to promote the general good of the community in local and national affairs. It shall further the education of the general public in health matters fostering a sane point of view about proper medical care.

Each component county society and district society shall designate one member at its annual meeting to serve with the Committee on Legislation in an active capacity. Vacancies in this special sub-committee shall be filled by the Presi-

dent. In addition, the Woman's Auxiliary shall be requested to form a similar committee with representatives from each component auxiliary. The President may appoint for one year an Advisory Committee of any number he deems advisable.

C) THE COMMITTEE ON MEDICAL EDUCATION shall consider and devise means of extending the educational work of the Association for the benefit of its members, working with the component societies whenever possible and serve for the Council on Medical Education of the American Medical Association in this state. All problems relating to the postgraduate study of medicine shall be referred to this committee.

D) THE COMMITTEE ON MEDICAL DEFENSE. The Committee on Medical Defense shall consist of five members of whom the Chairman of the Council and the Secretary-Treasurer shall be members. The other members, one of whom shall be elected Chairman, shall be elected by the Council for terms of five years each. The duties of this Committee shall be to investigate and defend all damage suits brought against the Medical Association of Georgia; to investigate all claims of alleged malpractice made against its members and to take full charge of such cases that are deemed to be worthy of defense; to defend all such cases in the courts of last resort, to furnish General Counsel and pay court costs usual to such litigation, and reasonable fees for local attorneys as shall be arranged by Council. Any member who has indemnity insurance shall have such insurance bear its portion of the expense. However, they shall not pay or obligate The Medical Association of Georgia to pay any judgment rendered against any member upon the final determination of any case. It shall be empowered to contract with such agents and attorneys as it may deem necessary for the proper carrying out of this By-Law. The assistance for defense, as herein provided shall be available only to members of The Medical Association of Georgia in good standing.

Any member of the Association threatened with suit for alleged civil malpractice shall immediately communicate with the Secretary-Treasurer of the Association and shall give full and complete information in reference to all the circumstances alleged in the complaint. He shall immediately notify the Chairman of this committee who shall investigate the circumstances reported and shall advise with the attorneys or agents employed by the committee for this purpose. The member sued, or threatened with suit, shall be consulted and shall have the complete confidence of the committee in all transactions connected with the investigation in question. The committee shall have the authority to require of a constituent society or the president thereof, the appointment of a committee of investigation in any such case, and it may direct the committee so appointed to report to the Committee on Medical Defense and not to the society from which it was appointed.

The Committee on Medical Defense may assist in the prosecution of illegal practitioners in the State of Georgia and assist in the enforcement of the Medical Practice Act of this State.

E) THE COMMITTEE ON PROFESSIONAL CONDUCT. The Committee on Professional Conduct shall consist of the five more recent past presidents of the Association. The senior member shall be Chairman. It shall investigate all complaints relating to or involving the ethical or professional practice of any member of The Medical Association of Georgia. All complaints or accusations against any member of The Medical Association of Georgia relative to irregular practice, excessive fees, habitual failure to respond to calls without adequate reason, extravagant or questionable statements made as witnesses in a court of law, or any act calling for disciplinary measures or investigation of a member, shall become the concern of this Committee. Complaints may be made by an individual patient, physician, board of censors, of any local medical society, attorney, or any officer

of a regularly constituted court of law. Upon receipt of notice of such complaint, the Committee, through its individual members or some competent person designated by it, shall immediately investigate the charges, and if the Committee is convinced that there is sufficient justification for a hearing the physician shall be requested to appear before at least three members of said Committee to answer charges. Such hearing shall be conducted in private and the source of information and charges will be divulged only at such hearing. No member of this Committee shall sit in a hearing involving a physician from his Councilor District.

After deliberation, the Committee shall have a choice of one of the four following dispositions:

1. Dismiss the case because of insufficient grounds for a legitimate complaint.
2. Attempt a satisfactory adjudication of the complaint.
3. Suggest to the physician changes in his conduct and relationship with his patients, in order that he may not bring unfavorable criticism upon his profession.
4. Refer to the Council of The Medical Association of Georgia all cases in which the action by the Council is deemed necessary, together with recommendations as to disciplinary measures to be taken by the Council of The Medical Association of Georgia.

Nothing in this By-Law shall be construed to prevent the selection and active participation in all the functions enumerated above by each component county society.

F) THE COMMITTEE ON HISTORY AND VITAL STATISTICS. It shall be the duty of the Committee on History and Vital Statistics to stimulate and promote the preparation of suitable articles on the history of the Association and its members, and shall recommend their publication to The Journal of the Association. It shall prepare memorials for deceased members, and arrange for their publication. It shall also report to the House of Delegates all new and eligible physicians who were licensed in the State during the past year indicating those who have become members of the Association. The Editor of *The Journal* and the President of the State Board of Medical Examiners shall be ex-officio members of this Committee.

G) THE COMMITTEE ON PUBLIC HEALTH. The Committee on Public Health shall be assisted by a sub-committee of one member elected by each county and district society of the state. Its duty shall be to advise with the Governor and other State officials, and with the Georgia State Board of Health and other related groups in regard to all matters concerning the health of the citizens of Georgia. It shall meet at the time of each session of the Georgia State Legislature with the Committee on Legislation to give assistance in carrying out its duties.

The President may appoint for one year an Advisory Committee of any number he deems advisable.

H) THE COMMITTEE ON MATERNAL AND INFANT WELFARE shall be composed of seven members, three of whom shall be general practitioners. It shall regularly review and analyze the causes of all maternal deaths occurring in the State. It shall investigate conditions affecting maternal care in Georgia and make recommendations concerning improvements thereof. It shall establish a working liaison with the Georgia State Obstetrical and Gynecological Society and the Georgia Pediatric Society and shall consider the establishment of annual post-graduate regional courses in obstetrics throughout the State with the cooperation of the Committee on Medical Education and Hospitals.

I) THE COMMITTEE ON RURAL HEALTH shall concern itself with improving medical service in the more sparsely settled areas in the State. It shall be composed of one member from each of the Councilor Districts comprising the Association, in addition to the Director of the State Department of Public Health who shall be a member ex-officio. It shall investigate and make recommendations as to locating and staffing health centers and shall cooperate with the

Council on Rural Health of the American Medical Association. The Committee shall designate a member to represent the Medical Association of Georgia at national conferences on rural health.

J) THE COMMITTEE ON INDUSTRIAL HEALTH shall be composed of five members. The committee shall confer with both labor and management in stressing the importance of preventive rather than curative medicine. It shall investigate and make recommendations concerning initiation of programs designed to improve safe working conditions for employees and to solve other industrial health problems. It shall cooperate in all respects with the Council on Industrial Health of the American Medical Association.

K) THE COMMITTEE ON PUBLIC RELATIONS shall be appointed by the President. It shall be the duty of the committee to integrate and publicize all approved plans and projects emanating from the Council and other standing and special committees of the Association. It shall consider all policies and make suggestions and recommendations for improving or changing such policies for the purpose of integration and publicizing. It shall develop additional projects for bettering and understanding between physicians and the public.

L) THE COMMITTEE ON CANCER shall consist of one representative from the Association, one from each of the State-Aid Cancer Clinics, and one each from the Medical Colleges in the State who shall serve not less than three years, and the President shall appoint the chairman from among the members having the longest service. The chairman shall submit a list of physicians' names representing these groups for appointment by the President. An Executive Committee of this committee consisting of not less than six members shall be appointed by the President upon recommendation of the chairman.

It shall be the duty of this committee to represent the members of the Association in dealing with all matters pertaining to cancer, and in particular, it shall advise with the Division of Cancer Control of the Department of Public Health.

M) THE COMMITTEE ON INSURANCE or Insurance Board shall consist of not less than five members appointed for a period of five years in rotation by the President. The committee may elect one of its members to be chairman or request the President to designate a member as chairman. Members appointed during the first four years shall serve staggered terms as designated by the President.

The four geographical quadrants and the central industrial area shall have representation on this committee. Also the Chairman may nominate five lay persons with known interest in the field of insurance for appointment by the President, who shall serve with the Board in an advisory capacity.

It shall be the duty of this committee to formulate and administer all policies and plans pertaining to insurance insofar as such concern members of the Association. In particular it shall sponsor and promote the Georgia Plan including provisions for necessary expenses.

N) THE COMMITTEE ON VETERANS AFFAIRS shall represent the Association in all matters pertaining to all veterans.

O) THE COMMITTEE ON CONSTITUTION AND BY-LAWS shall recommend to the House of Delegates any amendments which seem to be necessary or advisable. Proposed amendments shall be referred to this committee before action is taken by the House of Delegates.

P) THE COMMITTEE ON AWARDS shall have complete charge of all awards made by the Association or in the name of the Association. The decisions of this Committee shall be final in reference to recipients.

Q) THE COMMITTEE ON THE WOMAN'S AUXILIARY shall cooperate with, advise and direct the Auxiliary in all matters concerning the Association.

R) THE COMMITTEE ON HOSPITALS shall pursue a continuing study of the relation of the medical profession to the operation of public and voluntary hospitals within this State

and shall, when indicated, confer with the State Department of Health, the Georgia Hospital Association and all related organizations and make recommendations to the Association.

Will Read:

CHAPTER IX.
Standing Committees

SECTION 1. *The Standing Committees of the Association shall be as follows:*

- A) *Committee on Legislation*
- B) *Committee on Medical Education*
- C) *Committee on Medical Defense*
- D) *Committee on Professional Conduct*
- E) *Committee on History and Vital Statistics*
- F) *Committee on Public Health*
- G) *Committee on Maternal and Infant Welfare*
- H) *Committee on Rural Health*
- I) *Committee on Industrial Health*
- J) *Committee on Public Service*
- K) *Committee on Cancer*
- L) *Committee on Insurance and Economics*
- M) *Committee on Veterans Affairs*
- N) *Committee on Constitution and By-Laws*
- O) *Committee on Scientific Exhibit Awards*
- P) *Committee on Woman's Auxiliary*
- Q) *Committee on Hospital Relations*
- R) *Committee on Crawford W. Long Memorial*
- S) *Committee on Mental Health*
- T) *Committee on Geriatrics*

SECTION 2. *Unless otherwise provided in these By-Laws, each of these committees shall consist of three members, each of whom shall serve for three years. Unless otherwise provided in these By-Laws, Executive Committee of Council shall appoint standing committee members and standing committee chairmen as needed. One member of each standing committee shall be appointed each year by the Executive Committee of Council to serve for three years. The Executive Committee shall make all appointments at least thirty days prior to the annual session and all standing committees shall hold their organizational meeting at the time of the annual session. The members of each committee shall serve staggered terms of office so that only one term shall expire each year. The President, with the approval of Council, may replace any member of any committee who fails to show interest in performing the committee duties assigned him. All committee chairmen shall make an annual report in writing to the Association headquarters office sixty days in advance of the annual session for consideration by the House of Delegates.*

(A) Proposed complete deletion.

SECTION 3. (A) COMMITTEE ON LEGISLATION. *The Committee on Legislation shall be composed of a chairman who shall have charge of matters pertaining to State of Georgia Legislation; a vice-chairman, who shall have charge of matters pertaining to legislation of the Congress of the United States, and three other members. The chairmen of the following committees shall serve as ex-officio members without the right to vote: Medical Education, Public Health, Maternal and Infant Welfare, Rural Health, Industrial Health, Insurance and Economics, Veterans' Affairs, Hospital Relations and Mental Health. The President of the State Board of Medical Examiners and the Chairman of the State Board of Health shall also be ex-officio members of this committee without the right to vote.*

The duties of the committee shall be to represent the Association in securing and enforcing State of Georgia and Federal Legislation as directed by Council, in the interests of public health and scientific medicine. The Committee shall meet at least sixty days prior to the convened sessions of either the Georgia General Assembly or the Congress of the United States. The committee shall appoint at least ten key men, one from each congressional district to represent the committee in their area on matters pertaining to legislation of the Congress of the United States. As many other keymen as are needed shall be requested to represent the

committee on matters pertaining to State of Georgia legislation.

SECTION 3. (B) COMMITTEE ON MEDICAL EDUCATION. *The Committee on Medical Education shall be composed of a chairman and two other members and the deans of the medical schools in the State of Georgia who shall serve in an ex-officio capacity without the right to vote. The committee shall consider and devise means of extending the educational work of the Association for the benefit of its members, working with the component societies whenever possible and serve for the Council on Medical Education of the American Medical Association in this State. The Committee shall act as an advisory body in matters concerning medical education as directed by Council. All problems relating to the postgraduate study of medicine shall be referred to this Committee.*

SECTION 3. (C) COMMITTEE ON MEDICAL DEFENSE. *The Committee on Medical Defense shall consist of five members of whom the Chairman of the Committee on Finance and the Secretary shall be members. The other members, one of whom shall be appointed chairman, shall be appointed by the Executive Committee of Council for terms of five years each. The duties of this Committee shall be to investigate any claim of alleged malpractice made against any member upon the written request to the Committee by said member. The Committee shall, on the advice of Counsel, in cases being worthy of defense, furnish the services of the Association counsel for the purpose of consultation and advice relative to threatened or actual litigation provided the Association does not assume financial obligation in excess of \$100.00 for any one member in any calendar year. Any charges or fees in excess of \$100.00 for any one member in any calendar year shall be borne by the member so requesting the privilege of medical defense consultation and advice as stated herein.*

SECTION 3. (F) COMMITTEE ON PUBLIC HEALTH. *The Committee on Public Health shall be composed of a chairman and a member of the Georgia State Department of Health appointed by the Executive Committee of Council of the Medical Association of Georgia and the chairman of each of the following Association committees: Industrial Health, Rural Health, Hospital Relations, Legislation, Medical Civil Preparedness, Mental Health, Crippled Children, Maternal and Infant Welfare, Geriatrics, Cancer, Insurance and Economics and Blood Banks. The chairmen of these committees shall then automatically be members of the Association's Public Health Committee and shall select an alternate member from each of their respective committees to represent them at Public Health Committee meetings in the absence of the chairman. It shall be the duty of the Public Health Committee to meet at least annually to hear reports from the Committee chairmen members so named, to correlate their activities and to act as a "clearing house" for any matters concerning public health. It shall also be the duty of the Public Health Committee to correlate these activities with the Georgia Department of Public Health.*

SECTION 3. (G) COMMITTEE ON MATERNAL AND INFANT WELFARE. *The Committee on Maternal and Infant Welfare shall be composed of three or more general practitioners, three or more obstetricians and three or more pediatricians. Terms of office shall be for a period of three years with one-third of the members appointed annually by the Executive Committee of Council. The committee shall regularly review and analyze the causes of all maternal deaths and perinatal losses occurring in the State for the purpose of recommending improvement. It shall also investigate conditions affecting maternal and infant care in Georgia and make recommendations concerning improvements thereof. The committee shall meet a minimum of twice annually.*

SECTION 3. (H) COMMITTEE ON RURAL HEALTH. *The Committee on Rural Health shall concern itself with improving medical service in the more sparsely settled areas in the State. It shall be composed of one member from each of the*

Councilor Districts comprising the Association as appointed by the Executive Committee of Council, and in addition, a member of the State Department of Public Health who shall serve as a member *ex-officio* without the right to vote. It shall investigate and make recommendations as to locating and staffing health centers and shall cooperate with the Better Health Council of Georgia, and the Council on Rural Health of the American Medical Association.

SECTION 3. (J) COMMITTEE ON PUBLIC SERVICE. The Committee on Public Service shall be appointed by the Executive Committee of Council. It shall be the duty of the committee to integrate and publicize all approved plans and projects emanating from the Council and other standing and special committees of the Association. It shall consider all policies and make suggestions and recommendations for improving or changing such policies for the purpose of integration and publicizing. It shall develop additional projects for bettering understanding between physicians and the public.

SECTION 3. (L) COMMITTEE ON INSURANCE AND ECONOMICS. The Committee on Insurance and Economics shall consist of not less than ten members, one from each Councilor district, to be appointed for a period of three years in rotation by the Executive Committee of Council and the Executive Committee shall appoint one of these chairman. The chairman may nominate lay persons with known interest in the field of insurance for appointment by the Executive Committee to serve in an advisory capacity.

SECTION 3. (O) COMMITTEE ON SCIENTIFIC EXHIBIT AWARDS. The Committee on Scientific Exhibit Awards shall have complete charge of all awards made by the Association or in the name of the Association for scientific exhibitors at the annual session.

SECTION 3. (Q) COMMITTEE ON HOSPITAL RELATIONS. The Committee on Hospital Relations shall pursue a continuing study of the relation of the medical profession to the operation of public and voluntary hospitals within this state and shall, when indicated, confer with the State Department of Health, the Georgia Hospital Association and all related organizations and make recommendations to this Association.

SECTION 3. (R) COMMITTEE ON CRAWFORD W. LONG MEMORIAL. The Committee on Crawford W. Long Memorial shall supervise matters pertaining to the Crawford W. Long Memorial and shall represent the Association in such matters subject to the approval of Council.

SECTION 3. (S) COMMITTEE ON MENTAL HEALTH. The Committee on Mental Health shall promote the welfare of the mentally ill in the State of Georgia and shall constantly seek means of improving care for the mentally ill in the State.

SECTION 3. (T) COMMITTEE ON GERIATRICS. The Committee on Geriatrics shall concern itself with the medical problems of the aged and chronically ill patient and pursue a continuing study of this problem as it affects the public health.

Now Reads:

CHAPTER X.
Special Committees

Special committees may be created at any time when the necessity arises. Their necessity must be approved by the Council and they shall be appointed by the President.

Will Read:

CHAPTER X.
Special Committees and Executive Secretary

SECTION 1. SPECIAL COMMITTEES. Special Committees may be created at any time when the necessity arises. Their necessity must be approved by the Council and they shall be appointed by the President.

SECTION 2. EXECUTIVE SECRETARY. The Executive Secretary shall be the administrative agent of this Association, of its Council and of all its committees. He shall be the executive agent of the Association transacting its business under the direction of the Executive Committee of Council and shall be the directing manager of the Headquarters Office. He shall discharge the administrative functions of the Association not within the duties of the Association officers and

committees and shall keep himself informed in regard to non-professional matters affecting the medical profession. He shall be responsible to the Executive Committee of Council for the execution and carrying out of the policies of the Association and in that connection shall perform all specific tasks committed to him by the committees, the Council and the officers of the Association.

The selection, terms of employment and salary of the Executive Secretary shall be determined by the Executive Committee of Council, subject to the approval of Council. The Executive Secretary shall be responsible to the Executive Committee of Council and the Executive Secretary shall prepare a report on the activity and status of the Headquarters Office for the Executive Committee of Council at each of their meetings to keep the committee informed at all times.

Now Reads:

CHAPTER XI.
The Journal

SECTION 1. The Journal of the Medical Association of Georgia herein referred to as The Journal, shall be under the control and direction of the Council. It shall appoint an Editor, and an Editorial Board and make any other provisions for the publication of The Journal which in its judgment are necessary. Such appointee or appointees shall serve at the pleasure of the Council, which shall have full discretionary power to promulgate rules and regulations governing the publication of The Journal; enumerate and define the powers and duties of the Editor or Editorial Board, or both; and fix the terms and conditions of their appointment.

Will Read:

CHAPTER XI.
The Journal

SECTION 1. The Journal of the Medical Association of Georgia herein referred to as The Journal, shall be under the control and direction of the Council. It shall appoint an Editor and an Editorial Board annually and make any other provisions for the publication of The Journal; enumerate and define the powers and duties of the Editor or Editorial Board, or both; and fix the terms and conditions of their appointment.

SECTION 4. The Executive Committee of the Council shall constitute the Publications Committee of the Journal.

Now Reads:

CHAPTER XII.
Rules and Ethics

SECTION 1. The Principles of Ethics of the American Medical Association shall govern the members of the Association.

Will Read:

CHAPTER XII.
Rules and Ethics

SECTION 1. The Principles of Ethics of the American Medical Association, this Constitution and By-Laws as now set forth or as may be hereafter amended and the standards of the profession in Georgia shall govern the conduct of the members of this Association.

Will Read:

STANDING RULES

1. The Committee on Scientific Work shall prepare the program for all scientific meetings of the Association at all Annual Sessions. It may divide the scientific work into whatever number of sections that seem advisable for the particular Annual Session. It shall appoint temporary officers for all sections until such time as the sections apparently become permanent. As each section becomes established it shall elect its own officers to such rules and regulations as may be laid down by the Committee on Scientific Work. The program for all general meetings shall be prepared by the Committee itself. In its work the Committee shall be subject to the approval of the Council, and when necessary, to the House of Delegates.

2. The Executive Committee of the Council shall constitute the Publications Committee of The Journal.

STANDING RULES

Proposed complete deletion.

BY-LAWS

Reference Committee Recommendation—Reference Committee No. 6 considered each item individually in the By-Laws and wishes to make the following recommendation in Chapter 1, Section 3 as follows: "We recommend the addition of the following sentence 'That all eligible members should be encouraged to be active members.' We further recommend in Chapter 9, Section 3(0) that the Committee on Scientific Exhibits and Scientific Awards should have complete charge of all Scientific Exhibits and Scientific Awards made by the Association or in the name of the Association for Scientific Exhibitors and Scientific Awards at the Annual Session. We further recommend unanimously that the By-Laws as written above and changed above be approved as amended without further change. Your reference committee wishes to take this opportunity to congratulate the Association's Committee on Constitution and By-Laws for a wonderful job well done, and personally wishes to thank the following members of that committee: J. W. Chambers, LaGrange, chairman; Thomas W. Goodwin, Augusta; William P. Harbin, Jr., Rome; Eustace A. Allen, Atlanta; and David Henry Poer, Atlanta.

House of Delegates Action—Recommend the adoption of the By-Laws with the changes recommended by the reference committee, which was moved, seconded and adopted.

Speaker and Vice-Speaker Election

Speaker Goodwin then turned the chair over to President Allen pursuant to the adoption of the By-Laws. President Allen called for nominations for a three-year term of office as called for on the adoption of the By-Laws for the offices of Speaker and Vice-Speaker.

Placed in nomination were the names of Thomas W. Goodwin, Augusta, for Speaker of the House of Delegates, and Fred H. Simonton, Chickamauga, for Vice-Speaker of the House of Delegates, and there being no further nominations the president instructed the secretary to cast a unanimous ballot in behalf of the delegates for the election of Thomas W. Goodwin of Augusta as Speaker of the House of Delegates and Fred H. Simonton, Chickamauga, as Vice-Speaker of the House of Delegates.

Life Membership

The chair was then turned over to Speaker Goodwin, and he read the following list of members in good standing nominated by this county medical societies for Life Membership in the Medical Association of Georgia:

W. E. Wofford, Chatsworth; G. Y. Massenburg, Sr., Macon; J. E. Lester, Marietta; M. S. Levy, Smyrna; W. P. Ezard, Lawrenceville; W. W. Puett, Norcross; Carl B. Welch, Attapulgus; Montague L. Boyd, Atlanta; Frank Eskridge, Atlanta; Harry N. Kraft, Atlanta; J. Calhoun McDougall, Atlanta; Marion C. Pruitt, Atlanta; M. A. Acree, Calhoun; C. D. Whelchel, Gainesville; W. K. Swann, Covington; O. R. Styles, Cedartown; C. K. Sharp, Arlington; Lewis Beason, Butler; C. S. Floyd, Loganville.

On motion made and seconded, these members were approved for Life Membership by the House of Delegates.

The meeting was adjourned at 6:30 p.m.

General Business Session (Second Session)

Wednesday, May 16, 1956

THE SECOND GENERAL BUSINESS SESSION of the 106th Annual Session of the Medical Association of Georgia was called to order by President H. Dawson Allen, Jr., Milledgeville, at 9:35 a.m. in the Exhibit Hall Meeting Room, Atlanta Biltmore Hotel, Atlanta, Georgia.

President Allen called on Secretary David Henry Poer for the presentation of Fifty Year Certificates to physicians who have practiced medicine for 50 years or more. These presentations were made to the following physicians:

Guy D. Ayer, Atlanta; H. F. Bent, Midville; E. Cleveland Bridges, Donalsonville; Henry C. Ellis, McDonough; William P. Ellis, Chipley; George T. Hendry, Blackshear; Charles A. Hodges, Dublin; C. H. Pinson, Atlanta (Deceased); W. W. Puett, Norcross; D. S. Reese, Carrollton; Charles L. Ridley, Sr., Macon; O. W. Roberts, Carrollton; C. E. Stapleton, Statesboro; Carl B. Welch, Attapulgus; George M. White, Rockmart (Deceased); Charles O. Williams, West Point; J. C. Wooldridge, Columbus, and Carl L. Anderson, Macon.

President Allen then called on J. W. Chambers, Chairman of Council, for the presentation of the Hardman Award. Dr. Chambers reported that at the last meeting of Council it was recommended and unanimously approved that the Hardman Award not be awarded at the 106th Annual Session due to the small number of nominations for this high honor. Dr.

Chambers also informed the assembly that Council further recommended that nominations received for this award this year be held over until next year, at which time it was hoped that more nominations would be received.

President Allen called upon Secretary Poer to make the announcement and award presentation for "General Practitioner of the Year." This award was presented to Sterling Jernigan, Sr., Sparta.

President Allen called upon Secretary Poer, acting for the Council of the Medical Association of Georgia, for the presentation of Certificates of Appreciation from the Association. Dr. Poer called upon Robert C. Major, Augusta, to present a Certificate of Appreciation to Mrs. Robert C. Major, Augusta, for her service as President of the Woman's Auxiliary to the Medical Association of Georgia.

Dr. Poer called on C. H. Richardson, Sr., Macon, to present a Certificate of Appreciation to H. Dawson Allen, Jr., Milledgeville, for his service as President of the Medical Association of Georgia, and Dr. Allen also was presented with the President's Key.

Secretary Poer then called on J. C. Hughston of Columbus to present a Certificate of Appreciation to Fred G. Hodgson for his service in the Crippled Children's Program in the State of Georgia.

Secretary Poer then called on Grady N. Coker, Chairman of the Association Legislation Committee, and William H. Kiser, Jr., Atlanta, to present a Certificate of Appreciation to Mr. John Finley Kiser, Assistant Executive Secretary of the Association's Headquarters Office for his service to the profession in liaison with the Georgia General Assembly, under the direction of Association's Legislation Committee.

Secretary Poer called on W. F. Reavis, Waycross, Past President, to present a Certificate of Appreciation to Neal F. Yeomans, Waycross, for his service to the Association as Councilor.

Secretary Poer called on Walker Jernigan, Atlanta, to present a Certificate of Appreciation to Mark S. Dougherty, Jr., Atlanta, for his service to the Association as Councilor from the Fifth District.

President Allen called on Awards Committee Chairman Ted F. Leigh, Atlanta, to present the awards for Scientific Exhibits at the 106th Annual Session. Dr. Leigh presented the following awards:

First Place—"Histerography," A. C. Richardson, M.D., George A. Williams, M.D., and William W. Bryan, M.D., Atlanta.

Second Place—"Radiologic Investigation of Larynx and Pharynx," Brit B. Gay, Jr., M.D., and Joseph Chang, M.D., Emory University.

Third Place—"Bony Landmarks in Joint Paracentesis," Arthur M. Pruce, M.D., James Miller, Ph.D., I. R. Berger, M.D., and Albert Lansing, Ph.D., Atlanta.

Dr. Leigh then made the presentation for honorable mention which included:

"Plastic Surgery for Defects of the Mid-Face," W. Stewart Flanagan, M.D., Augusta.

"Treatment of Skin Tumors," R. C. Pendergrass, M.D., Americus.

"Vascular Grafting," William A. Hopkins, M.D., M. Bedford Davis, M.D., and William C. Wansker, M.D., Atlanta.

President Allen then called on William E. Goodyear, Chairman of the Golf Committee, to award the golf prizes. Dr. Goodyear made the presentation for "low gross" winner to Harry W. Ridley, Atlanta; "runner-up," J. Harry Rogers, Atlanta. Dr. Goodyear announced that there was a tie for "low net" winners and the doctors winning this award were J. C. Patterson, Cuthbert, and Joseph L. Mulherin, Augusta.

President Allen then presented a resolution in behalf of the Council of the Medical Association of Georgia which was submitted to the Professional Conduct Committee for approval and with their approval so rendered unanimously passed by the House of Delegates as follows:

WHEREAS, Dr. William S. Jones, formerly a native of Georgia now residing in Menominee, Michigan, has distinguished himself in the field of medicine and is presently the President of the Michigan State Medical Society; and,

WHEREAS, Dr. Jones, well known to Georgia practitioners, has served the medical profession in promoting the art and science of medicine; and,

WHEREAS, the Executive Committee of Council of the Medical Association of Georgia wishing to in some way recognize Dr. Jones' distinguished contributions to the profession recommended to the Association Council that honor be bestowed this physician; and,

WHEREAS, the Council of the Medical Association of Georgia approved the recommendation of its Executive Committee;

THEREFORE, BE IT RESOLVED, that the House of Delegates of the Medical Association of Georgia confer Honorary Membership for Dr. William S. Jones, Menominee, Michigan, in recognition of this physician's distinguished and exemplary career in service to our profession.

President Allen then announced that by unanimous action of the House of Delegates the 1957 meeting place for the Annual Session of the Association would be Savannah, Georgia, at the invitation of the Georgia Medical Society.

Installation of 1956-57 Officers

The next order of business was the installation of 1956-57 officers which were as follows:

President, Hal M. Davison, Atlanta.

President-Elect, W. Bruce Schaefer, Toccoa.

Immediate Past President, H. Dawson Allen, Jr., Milledgeville.

First Vice-President, Carl C. Aven, Atlanta.

Second Vice-President, Bernard P. Wolff, Atlanta.

Councilor 5th District, J. G. McDaniel, Atlanta.

Vice-Councilor 5th District, Charles S. Jones, Atlanta.

Councilor 6th District—Henry H. Tift, Macon.

Vice-Councilor 6th District, George H. Alexander, Forsyth.

Councilor 7th District, D. Lloyd Wood, Dalton.

Vice-Councilor 7th District, Ralph W. Fowler, Marietta.

Councilor 8th District, F. G. Eldridge, Valdosta.

Vice-Councilor 8th District, James N. Hicks, Brunswick.

AMA Delegate, Eustace A. Allen, Atlanta.

AMA Alternate Delegate, William R. Dancy, Savannah.

AMA Delegate, Spencer A. Kirkland, Atlanta.

AMA Alternate Delegate, Henry H. Tift, Macon.

President Allen then announced the official registration figures for the 106th Annual Session as follows: MAG member physicians, 912; physicians (residents, interns and out of state physicians), 132; guests (medical students), 125; and others, 22; making a total registration of 1,191.

On motion of David Henry Poer, which was duly seconded and unanimously approved, the assembly gave a rising vote of thanks to the Medical Association of Georgia Scientific Work Committee and the Fulton County Medical Society Local Arrangements Committee, and also commended the Biltmore Hotel for their cooperation. It was further moved that the assembly commend Miss Edwina Davis of the *Atlanta Journal* and Miss Katherine Barnwell of the *Atlanta Constitution* for their excellent objectivity in reporting for the public the events of the 106th Annual Session.

The meeting adjourned at 10:15 a.m.

MAG Membership Classification Chart

By-Laws; Chapter I, Section 3: Membership in the Association shall be classified as Active, Service, Associate and Honorary and all eligible members should be encouraged to be active members.

Classification of Membership	Classification Description	Privileges	Term	MAG Dues	MAG Journal	Method of Election
1. Active	Physicians who are members in a component county medical society and are eligible to vote and hold office in the society shall be Active members unless otherwise classified by the action of the component society. All eligible members should be encouraged to be Active members.	Full membership privileges including holding office and voting and medical defense.	1 yr.	\$25.00 annually. \$12.50 for new members after July 1.	Included in dues.	Elected by component county medical society in accordance with MAG Constitution & By-Laws.
Active (Dues Exempt)	Active members may be excused from payment of MAG dues if so classified and reported by component society for one of following reasons: (1) financial hardship; (2) post-graduate training; (3) temporary service in reserve armed forces; and (4) past the age of 70 years; as defined in MAG Constitution and By-Laws.	Privilege of holding office and voting only.	1 yr.	None if component society also grants dues exemption.	By personal subscription only @ \$5.00 annually.	Same as above.
2. Service	Full-time (career) commissioned medical officers of the Government in the U. S. Army, Navy, Air Force, U. S. Public Health Service, Veterans Administration, Indian Service, and those physicians retired from these Services by Federal law and who do not engage in active practice as defined in MAG Constitution and By-Laws.	May not vote or hold office or receive medical defense.	1 yr.	None if component society also grants dues exemption.	By personal subscription only @ \$5.00 annually.	Same as above.
3. Associate	Physicians engaged in State and County Medical Services and full-time salaried members of approved medical facilities not engaged in private practice provided similar classification granted by component society. Also Associate membership may be granted to any member of component county medical society if so classified by that society as defined in MAG Constitution and By-Laws.	May not vote or hold office or receive medical defense.	1 yr.	None if component society also grants dues exemption.	By personal subscription only @ \$5.00 annually.	Same as above.
4. Honorary	Physicians or persons holding degree of Doctor of Medicine or Doctor of Philosophy who have risen to prominence in their professions.	May not vote or hold office or receive medical defense.	Permanent	None	By personal subscription only @ \$5.00 annually.	Nominated by component county societies or MAG Council and elected by MAG House of Delegates.

Council Meeting Minutes

Executive Committee of Council

April 12, 1956, Atlanta

THE EXECUTIVE COMMITTEE of Council meeting was called to order by Chairman H. Dawson Allen, Jr., at the MAG Headquarters Office, Atlanta.

Present were: H. Dawson Allen, Milledgeville, President; J. W. Chambers, LaGrange, Chairman of Council; Hal M. Davison, Atlanta, President-Elect; David Henry Poer, Atlanta, Secretary, and W. Bruce Schaefer, Toccoa, Chairman of Finance Committee of Council. Also present was Chris McLoughlin, Atlanta, and Edgar Woody, Jr., Atlanta; Mr. Milton D. Krueger, Mr. John F. Kiser, and Miss Frances Porcher, Atlanta.

MINUTES—Mr. Krueger reviewed the March 17-18, 1956, Council meeting minutes for information only, and then presented the Executive Committee of Council meeting minutes of March 18, 1956, which were duly read and approved.

1956-1957 COMMITTEE APPOINTMENTS—Hal M. Davison, President-Elect, made appointments for the year 1956-57 with members of the Executive Committee. (They will be listed in the July *Journal*.)

BRUNSWICK HOSPITAL PROBLEM—Dr. Davison brought to the attention of the members of the Executive Committee problems concerning hospital-staff relationships at the Brunswick Hospital. It was moved that the Executive Committee of Council go on record in full support of any action which the Glynn County Medical Society might take in regard to hospital-staff problems in the area. The Headquarters Office was instructed to so notify the President and Secretary of the Glynn County Medical Society.

JOURNAL PUBLICATIONS PROBLEM—Edgar Woody, Jr., discussed the advantages and disadvantages in the present printing arrangement with Franklin Printing Company, and it was moved that the printing of the *Journal of the Medical Association of Georgia* be transferred to the Higgins-McArthur Company as soon as is feasible.

PUBLIC SERVICE COMMITTEE REPORT—Chris McLoughlin presented a report of the Public Service Committee implementation for (1) 106th Annual Session publicity, and (2) MAG 1956-57 projects and planning. On motion duly made this report was approved, and Dr. McLoughlin commended for his activity in this area.

TALMADGE MEMORIAL HOSPITAL—A letter from Stephen W. Brown dated April 6 was read to the Executive Committee of Council. After discussion and by general agreement, it was recalled that as far as the Executive Committee was concerned it was their impression that any "new" operational plans for the Talmadge Memorial Hospital must emanate from the authorities in charge of that institution. Members of the Executive Committee could not recall that they or the Council were to contact these authorities and it was felt that if some new plan were worked out for presentation at the House of Delegates meeting, May 13-16, 1956, it was, to the best of their recollection, to be worked out by those authorities. Executive Committee further requested the Secretary to so inform Dr. Brown.

LECTURESHIP COMMITTEE OF COUNCIL—By general agreement, the Executive Committee decided that the problem of lectureships for MAG Annual Session should be referred to the Reserve Fund Committee of Council.

S. A. M. A. CONVENTION SUPPORT—A letter from Miss Martha Dull, Secretary of the SAMA Chapter of the Medical College of Georgia, pertaining to funds and sponsorship of officers of that organization attending the National Student American Medical Association convention was brought to the attention of the Executive Committee of

Council. The matter was discussed and members of the Executive Committee expressed regret that it would not be able to approve such sponsorship because no funds were appropriated in the 1956 budget for such purpose. The Secretary was so instructed to inform Miss Dull.

JOINT COMMISSION FOR IMPROVEMENT OF PATIENT CARE PARTICIPATION—Darrell Ayer presented, in absentia, a three-page memo concerning the Association's participation in the Joint Commission for Improvement of Patient Care during the last three years. Listed in this memo were the advantages and disadvantages gained by such participation, and by general agreement of Executive Committee of Council, subject to Dr. Ayer's approval, it was recommended that the Association withdraw its support and participation in this Joint Commission for Improvement of Patient Care.

AMA DELEGATES INSTRUCTION AND RESOLUTION—By general agreement of the Executive Committee, it was recommended that the MAG-AMA Delegates be instructed as to the election of AMA officers. It was also recommended by the Executive Committee that Council prepare a resolution on the corporate practice of medicine, and that this resolution be given our AMA Delegates to introduce at the AMA House of Delegates meeting June 11, 1956.

CERTIFICATES OF APPRECIATION AND HONORARY MEMBERSHIP—After discussion, and on motion duly made and approved, it was moved that certificates of appreciation be given to H. Dawson Allen, Jr., President; Neal F. Yeomans, Councilor; Mark S. Dougherty, Jr., Councilor; and Mr. John F. Kiser, Assistant Executive Secretary. These certificates of appreciation to be presented at the 106th Annual Session May 13-16, 1956. It was also duly moved and approved that Honorary membership be given to W. S. Jones, Menominee, Michigan, President of the Michigan State Medical Society, at the 106th Annual Session of the Association.

ANNUAL SESSION INVITATIONS—By general agreement, it was approved that the following attorneys or their representatives be invited to attend the 106th Annual Session, Monday evening, May 14, General Session: Atlanta Bar Association President, Georgia Bar Association President, Mr. Byrd, etc.

FILE CABINETS—Executive Committee approved the purchase of file cabinets needed for the Headquarters Office.

THIRD DISTRICT BOARD OF HEALTH APPOINTMENTS—On recommendation of the Third District Medical Society, the Secretary was instructed to inform the Governor of the nomination of Robert H. Vaughan, Columbus, and M. F. Arnold, Hawkinsville, to fill the unexpired term of office of Dr. Brannen who resigned as a member of the State Board of Health from the Third District.

There being no further business, the meeting was adjourned at 7:15 p.m.

1955-1956 Council

May 12, 1956, Atlanta

FINAL MEETING OF THE 1955-56 Council was called to order at 7 p.m., Saturday, May 12, in the MAG Offices at the Academy of Medicine, Atlanta, by J. W. Chambers, LaGrange, Chairman.

Present were: H. Dawson Allen, Jr., Milledgeville, President; Hal M. Davison, Atlanta, President-Elect; R. C. McGahee, Augusta, First Vice-President; David Henry Poer, Atlanta, Secretary-Treasurer; and Councilors Lee Howard, Sr., Savannah; George R. Dillinger, Thomasville; W. G. Elliott, Cuthbert; J. W. Chambers, LaGrange; Mark S. Dougherty, Jr., Atlanta; Henry H. Tift, Macon; D. Lloyd Wood,

Dalton; Neal F. Yeomans, Waycross; W. Bruce Schaefer, Toccoa; and H. L. Cheves, Union Point. Vice-Councilors present were Clarence B. Palmer, Covington; J. G. McDaniel, Atlanta; Ralph W. Fowler, Marietta, and Charles R. Andrews, Canton. Also present were Thomas W. Goodwin, Augusta, Speaker of the House of Delegates; Edgar Woody, Jr., Atlanta, Editor of the *MAG Journal*; Chris J. McLoughlin, Atlanta, Chairman of the Public Service Committee of the MAG; Spencer A. Kirkland, Atlanta, AMA Delegate; and the Messrs. Milton D. Krueger and John F. Kiser of the MAG Headquarters Office.

The invocation was given by David Henry Poer and the minutes of the last meeting of Council, March 17-18, and the last Executive Committee meeting, March 18 and April 12, were read by Mr. Krueger. On a motion (Dillinger-El-liott) the minutes were approved as read.

Council approved the appointment by the Executive Committee of a special committee to handle the Annual Session in future years. Appointed to this committee were J. G. McDaniel, Chairman; Henry H. Tift; J. W. Chambers; David Henry Poer, and George Dillinger.

HARDMAN AWARD—Henry H. Tift, Macon, Chairman of the Hardman Award Committee, presented the report of the committee and submitted two names to the Council for consideration.

After some discussion it was moved that the Hardman Award would not be granted this year, and the two names submitted by the committee would be carried over until 1957.

GENERAL PRACTITIONER AWARD—Three physicians' names were presented for the General Practitioner Award by Council: George L. Broadrick, Dalton; Sterling Jernigan, Sparta, and Fred H. Simonton, Chickamauga. These names were forwarded by Council to the House of Delegates.

CERTIFICATES OF APPRECIATION—On a motion it was voted to approve the awards of Certificates of Appreciation made by the Executive Committee at its last meeting with the addition of Mrs. Robert Major, Augusta, and Fred G. Hodgson, Atlanta.

GLYNN COUNTY MEDICAL SOCIETY PROBLEM—Mr. Krueger read a letter from the Glynn County Medical Society thanking the Executive Committee for its prompt action in regard to a hospital-staff problem in Brunswick. This was accepted as information.

AMA DISTINGUISHED SERVICE AWARD—Mr. Krueger read a letter from Dr. Lull providing information for members of Council in regard to the AMA Distinguished Service Award. It was voted to accept this as information.

SENATOR WALTER F. GEORGE CORRESPONDENCE—Mr. Kiser read two telegrams that had been sent to Senator George, one in regard to H.R. 7225 and one in regard to the announced retirement of Senator George from the Senate. This material was received as information.

H.R. 7225—On a motion (Poer-Davison) it was voted that all Councilors be requested to contact Senators George and Russell within the next two days in regard to the MAG position on H.R. 7225.

Dr. Chambers reported on his trip to Washington in connection with the U. S. Chamber of Commerce meeting. Dr. Chambers met with the congressional delegation from Georgia, including both senators and all of the representatives.

EUGENE TALMADGE HOSPITAL—The special report of the committee appointed to review the Talmadge Memorial Hospital problem was approved. It had been sent to members of Council in advance of the meeting.

Thomas W. Goodwin, Augusta, presented a Resolution representing the views of several members of the Richmond County Medical Society as follows:

RESOLUTION

WHEREAS, the problem of ethical operation of the Eugene Talmadge Memorial Hospital has been of great concern

to the Medical Association of Georgia for the past several years; and,

WHEREAS, in the interests of medical education and medical practice in this state this problem must be resolved,

THEREFORE, BE IT RESOLVED, that the Council of the medical Association of Georgia, realizing its responsibility in this matter, wishes to submit the following recommendations:

1. That the Council request the Medical Association of Georgia House of Delegates to reiterate its conviction that the operational plan of the Eugene Talmadge Memorial Hospital, as approved by the Board of Regents, March, 1955, fails to meet the standards of medical ethics of the Medical Association of Georgia and American Medical Association in the following categories:

- (a) The plan violates the basic principles of the patient-physician relationship in that it interferes with the free choice of physician;
- (b) The plan permits the possible exploitation of physicians on the faculty of the Medical College of Georgia for the pecuniary gain of the state;
- (c) The plan deprives the physician of a voice in the expenditure of funds derived from the professional services rendered.

2. The Council further request that the House of Delegates of the Medical Association of Georgia petition the Board of Regents and the President of the Medical College of Georgia to take the following five steps in order to correct these deficiencies in medical ethics:

- (a) Amend the Board of Regents operational plan of March, 1955, to permit professional pay patients to be referred directly by their doctor to the desired faculty member;
- (b) Amend the operational plan to allow faculty members to see patients in consultation in other hospitals, other than government hospitals when so requested;
- (c) Amend the operational plan to provide for physicians rendering services to professional pay patients as follows:
 - (1) Allow physicians to bill those patients directly;
 - (2) Allow physicians themselves to collect the fees from those patients;
 - (3) Allow physicians to voluntarily turn those fees so collected over to the Research Fund as provided for in their contracts.
- (d) Amend the operational plan to provide that no full-time physician shall spend more than 20% of his time in the treatment of professional pay patients or collect from professional pay patients and turn over to the Research Fund more than 20% in excess of the amount of his salary in any calendar year;
- (e) Amend the operational plan to provide means by which faculty members turning money into the Research Fund shall be permitted to make recommendations and be consulted as to how such monies shall be expended.

BE IT FURTHER RESOLVED, that there is great need for adequate legal counsel and advice by the Medical Association of Georgia on this problem, and it is therefore recommended that the Association employ the services of the most competent legal counsel to study and advise the medical profession regarding the status of medical practice in the State of Georgia; and,

BE IT FURTHER RESOLVED, that nothing in this resolution be construed to imply that the Medical Association of Georgia is taking any legal steps against any hospital, the Board of Regents, or any other agency or organization, but simply means that the House of Delegates believes that legal counsel and advice is needed in order to solve this overall problem of the corporate practice of medicine. It is further felt that matters pertaining to the field of medical ethics should be judged solely by the Medical Association of Georgia.

gia and its component county medical societies and that matters of law should be handled and judged by the Association Legal Counsel.

After considerable discussion by Drs. Allen, Goodwin, McGahee, Poer, and Davison, it was moved that Dr. Goodwin's proposed resolution become a resolution from Council to the House of Delegates and that a Committee of Council be appointed to convey this resolution to the members of the House of Delegates. This motion carried with one dissenting vote.

Dr. Poer, Secretary, raised the matter of his having to be absent from the Monday General Session, and there being no disapproval, he was excused from this session. Dr. Chambers was appointed by Dr. Allen to serve as Secretary during the Monday morning meeting.

SUNDAY MEETINGS—Dr. Yeomans discussed the advisability of holding meetings on Sunday, particularly during the Annual Session. Dr. Poer pointed out that Sunday meetings after 2 p.m. had been approved by a recent session of the House of Delegates.

Dr. Chambers complimented the members of Council on their activity and work during the past year.

There being no further business, the meeting was adjourned.

1956-1957 Council

May 15, 1956, Atlanta

PRESIDENT HAL M. DAVISON, Atlanta, called the organizational meeting of the 1956-57 Council to order at 10:30 a.m.

Council members present included: George R. Dillinger, Thomasville; H. L. Cheves, Union Point; C. H. Richardson, Sr., Macon, AMA Delegate; W. G. Elliott, Cuthbert; J. W. Chambers, LaGrange; H. Dawson Allen, Jr., Milledgeville; J. G. McDaniel, Atlanta; W. Bruce Schaefer, Toccoa; Hal M. Davison, Atlanta; Henry H. Tift, Macon; Carl C. Aven, Atlanta; F. G. Eldridge, Valdosta; George H. Alexander, Forsyth; and D. Lloyd Wood, Dalton.

COUNCIL CHAIRMAN—President Davison called for

nominations for the office of Chairman of Council, and J. W. Chambers of LaGrange was nominated to this office. There being no further nominations, President Davison asked the Secretary to cast a unanimous ballot of Council for the election of Dr. Chambers as Chairman of Council.

VICE-CHAIRMAN—President Davison turned the Chair over to the elected Chairman of Council, J. W. Chambers, who, in turn, called for nominations for the office of Vice-Chairman of Council. George R. Dillinger, Thomasville, was nominated for Vice-Chairman of Council, and there being no other nominations, Chairman Chambers called upon the Secretary to cast a unanimous ballot of Council for the election of George R. Dillinger as Vice-Chairman of Council.

Chairman Chambers then welcomed the new Councilors, officers, and vice-councilors to the Council, and discussed their responsibilities.

1957 ANNUAL SESSION MEETING PLACE—It was moved, seconded, and approved that the 1957 Annual Session of the Medical Association of Georgia be held in Savannah and that the details of this meeting be presented to Council at their next meeting for the setting of the date and time of this meeting.

FINANCE COMMITTEE CHAIRMAN — Chairman Chambers then called for nominations for the Finance Committee Chairman and committee members, and by unanimous vote Dr. Dillinger was elected Chairman of the Finance Committee with J. G. McDaniel, Atlanta, and D. Lloyd Wood, Dalton, as committee members.

1956-57 MAG BUDGET—It was moved, seconded, and approved that the new Council reapprove the 1956-57 MAG budget as submitted to the Council at the December 17-18, 1955, Thomasville meeting of Council.

NEXT COUNCIL MEETING—By general agreement, it was moved, seconded and approved that the Council meet June 2-3, 1956, at Macon, Georgia, and it was also approved that the Executive Committee of Council meet on June 2, 1956, prior to the Council meeting in Macon.

Chairman Chambers then called for further business, and there being none, the meeting adjourned at 10:45 a.m.

New Members

Name	Address	Classification	County
Wilbur Dale Lundquist	23 E. Charlton St., Savannah	Active	Ga. Med.
William Vernon Gillikin	Twin City, Ga.	Active	Emanuel
Dale Edwin Dominy	5998 Peachtree Road, N.E., Atlanta 19	Associate	Fulton
Armand Elkin Hendee	Emory University Hospital, Emory University	Active	Fulton
David J. Sender	Muscogee County Health Dept., Columbus	Associate	Muscogee
James Thomas Atkins	University Hospital, Augusta	Associate	Richmond
Jerome A. Cope	University Hospital, Augusta	Associate	Richmond
Daniel S. de La Penha	University Hospital, Augusta	Associate	Richmond
Preston David Ellington	89 Myrtle Court, Augusta	Associate	Richmond
John R. Fair	Medical College of Georgia, Augusta	Associate	Richmond
Alfred Joseph Green	36 Butler Street, S.W., Atlanta 3	Associate	Richmond
Frank Crawford Story, Jr.	University Hospital, Augusta	Associate	Richmond
Charles Harold Watson	University Hospital, Augusta	Associate	Richmond

PLEASE NOTE CHANGE in MAG Constitution and By-Laws (approved May 15, 1956) concerning the privilege of medical defense for Active (dues paying) members:

"The duties of this Committee (Medical Defense) shall be to investigate any claim of alleged malpractice made against any member upon the written request to the Committee by said member. The Committee shall, on the advice of Counsel, in cases being worthy of defense, furnish the services of the Association counsel for the purpose of consultation and advice relative to threatened or actual litigation provided the Association does not assume financial obligation in excess of \$100.00 for any one member in any calendar year. Any charges or fees in excess of \$100.00 for any one member in any calendar year shall be borne by the member so requesting the privilege of medical defense consultation and advice as stated herein."

- EDITOR
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- EDITOR-IN-CHIEF
David Henry Poer, M.D.
- MANAGING EDITOR
Frances H. Porcher
- STAFF
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W. Bruce Schaefer, M.D.
H. Dawson Allen, Jr., M.D.
David Henry Poer, M.D.
J. W. Chambers, M.D.
George R. Dillinger, M.D.
- THE ASSOCIATION
Hal M. Davison, M.D., *Pres.*
H. Dawson Allen, Jr., M.D., *Past Pres.*
W. Bruce Schaefer, M.D., *Pres.-Elect*
Carl C. Aven, M.D., *1st Vice-Pres.*
Bernard P. Wolff, M.D., *2nd Vice-Pres.*
David Henry Poer, M.D., *Sec.-Treas.*
Thomas W. Goodwin, M.D., *Speaker*
Milton D. Krueger, *Exec. Sec.*
John F. Kiser, *Asst. Exec. Sec.*

The JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and Copyrighted, 1956, by the Medical Association of Georgia, 878 West Peachtree Street, N.E., Atlanta 9, Georgia. Published monthly under the direction of the Council of the Association. Subscription rates: \$5 per year; \$1 per single copy. Entered as second-class mail at the post office at Atlanta, Georgia, under the Act of March 3, 1879. Accepted for mailing for the general rate of postage provided for in Section 1103, Act of October 6, 1917, authorized November 14, 1928.

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COVER BY TED F. LEIGH, M.D.

MAG COUNTY SOCIETY OFFICERS

(This list can be no more correct than your county secretary makes it. Ed.)

1—ALTAMAHA

J. A. Bedingfield, Baxley, President
J. B. Brown, Baxley, Secretary

2—BALDWIN

Curtis Veal, Milledgeville, President
Harold E. Campbell, Milledgeville, Sec'y

4—BARTOW

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AMA Annual Meeting Roundup

Three of the four MAG resolutions introduced by the Georgia delegation met with favorable action by the House of Delegates at the AMA 105th Annual Meeting, June 11-15, in Chicago. The MAG's request for a nation-wide auto safety program; a commendation for the Sears-Roebuck Foundation for aid to physicians; and opposition to a AMA raise in AMA dues were all adopted. The MAG recommendation for regional AMA meetings was disapproved.

Major subjects acted on by the AMA were: hospital accreditation; evaluation of graduates of foreign medical schools; private practice by medical school faculty members; federal aid to medical education; and premature publicity on new drugs. Since the proceedings will soon appear in the *AMA Journal*, there is little need to review the transacted business.

Of particular interest was the AMA Delegates' action relative to the problem of private practice by medical school faculty members which has been under study by the Committee on Medical and Related Facilities of the Council on Medical Services. The AMA adopted a council report which stated that "it shall be the policy of the AMA that funds received from the private practice of medicine by salaried members of the clinical faculty of the medical school or hospital should not accrue to the general budget of the institution and that initial disposition of fees for medical services from paying-patients should be under the direct control of the doctor or doctors rendering the service."

This adopted report also said: "It is not in the public or professional interest for a third party to derive a profit from payment received for medical services, nor is it in the public or professional interest for a third party to intervene in the physician-patient relationship." It was further recommended that active liaison be developed between each county medical society and any medical school in its area.

Dr. David B. Allman, Atlantic City surgeon, was elected unanimously AMA president-elect for the coming year. He will succeed Dr. Dwight H. Murray of Napa, Calif., who took office as president at this session.

Professional Liability Rate Reduction

MAG Insurance and Economics Committee recently informed the membership that the Association-St. Paul Mercury Professional Liability Insurance Program premium rate has been reduced 10 per cent as of June 1, 1956. This reduction is based on the experience of the over 900 MAG members taking

advantage of the program. As an MAG member you are eligible for this coverage. Because Association members have supported the program, the trend of increasingly higher premium rates has been reversed.

To continue this rate reduction and benefit thereby, you are urged to support the MAG-St. Paul Mercury Professional Liability Program which has these advantages: (1) *reduction* of number of claims; (2) *protection* of medical integrity; (3) premium rating on a *local* basis; (4) *annual* review of insurance experience; (5) complete availability of program's *financial* status; and, lastly, as of June 1, a premium rate of 10 per cent below standard.

Contact your local St. Paul Mercury agent or write the MAG Headquarters Office for specific information.

Social Security Poll

A recent MAG Social Security Poll was conducted concerning physician sentiment on whether or not M.D.'s should be included under the Old Age and Survivors Insurance provisions of the Social Security Act. Approximately 2,650 Georgia physicians were sent a reply post card with "yes—no" questions on this subject. Some 1,857 doctors responded (roughly 69 per cent response). Questions asked were: (a) Do you favor extension of the Old Age and Survivors Benefits coverage of the Federal Social Security Act to include physicians? (b) Do you favor *compulsory* Social Security for physicians? and (c) Do you favor *voluntary* Social Security for physicians?

Tabulated response of this poll is as follows:

Question (a): YES—1,203; NO—445; NO ANSWER—209.
Question (b): YES—277; NO—1,095; NO ANSWER—485.
Question (c): YES—1,385; NO—280; NO ANSWER—192.

It appears evident that a majority (undefined) of physicians favor inclusion of M.D.'s under Social Security and that inclusion should be on a *voluntary* and *not compulsory* basis. This seems to be the pattern of response, and the results of this poll have been forwarded to the AMA Bureau of Medical Economic Research as recommended by the AMA House of Delegates.

MAG 1957 Savannah Annual Session

Council has scheduled the 1957 MAG Annual Session for April 21-24, 1957, to be held at the DeSoto Hotel, Savannah. If you wish to submit scientific papers to be presented at this meeting, please watch for a full-page announcement concerning Annual Session Section Chairmen, to be run in your *Journal* as the "First Call for Scientific Papers."

GAGP Meeting October 17-18

The Georgia Academy of General Practice has scheduled its 8th Annual Session at the Oglethorpe Hotel, Savannah, on Wednesday and Thursday, October 17-18, 1956. In conjunction with this program, the Georgia Diabetes Association will convene on the same site Friday, October 19, 1956. The two-day GP program will present nine out-of-state physicians and four Georgia physicians speaking on topics of particular interest to GP's. Both the GAGP Annual Session and the Diabetes program will be Category I approved for postgraduate hours. All physicians are cordially invited.

Georgia Plan Insurance

Under the direction of the Insurance and Economics Committee, the Georgia Plan of prepaid surgical and obstetrical service has been revised and will be sent to MAG members to support as participating physicians. Major changes in the revision include: higher fee schedule of payments; optional "In-Hospital Medical Supplement" and optional "Anesthesia Supplement"; service benefit based on *aggregate* income; exclusions based on patients having more than one policy covering care they receive, selecting accommodations more expensive than semi-private, receiving additional compensation for injury, etc. These revisions should make the plan more equitable and as such warrant the continued and increased support of MAG members.

MAG Medical Defense Privilege

Council of the Medical Association of Georgia requested that each active Association member be notified as to how and why the privilege of Medical Defense has been changed in the recent revision of the MAG Constitution and By-Laws (House of Delegates Action, May 15, 1956).

Because of extremely high expenses incurred by the MAG in the defense of suits against members, and because the privilege of Medical Defense was so written as to provide legal counsel through the court of last resort without restriction as to expense involved; it was recommended and subsequently approved that, in fairness to all members, some restriction be put on the amount expended in behalf of any one member per year. This is believed to be a more equitable arrangement and yet retains the advantages of Association Counsel for advice and consultation as a privilege of membership.

The Constitution and By-Laws now reads: "... the duties of this committee shall be to investigate any claim of alleged malpractice made against any member upon the written request to the committee by said member. The committee shall, on the advice of Council, in cases being worthy of defense, furnish

services of the Association counsel for the purpose of consultation and advice to threatened or actual litigation provided the Association does not assume financial obligation in excess of \$100 for any one member in any one calendar year. Any charge or fees in excess of \$100 for any one member in any calendar year shall be borne by the member so requesting the privilege of Medical Defense consultation and advice as stated herein." (From MAG By-Laws—Section 3-c.)

Hospital Care Study Commission

More than 900 physicians in selected areas recently received questionnaires in regard to indigent care, sent by the Hospital Care Study Commission. Those members are urged to cooperate in this important project which was established as a result of a recommendation of the 1955 MAG House of Delegates. Questionnaires are also being sent to county commissioners, hospitals, nursing homes, and welfare agencies.

MAG members of the commission are Milford B. Hatcher, Macon; Virgil B. Williams, Griffin; and William Harbin, Rome. Next meeting is scheduled for September 13.

Medical Practice Act

The first meeting of the Liaison Committee to Study Revision of the Medical Practice Act was held in Atlanta, June 13. The committee voted to make recommendations concerning revision of three specific parts of the act: expansion of the revocation section; addition of an injunction clause; and revision of the sections pertaining to the licensing of foreign graduates. Three subcommittees were appointed to study these subjects and meet July 25 with the full committee meeting in September. MAG members of the committee are Enoch Callaway, LaGrange, and David Henry Poer, Atlanta. Albert M. Deal, Statesboro, and Grady N. Coker, Canton, represent the State Board of Medical Examiners.

Rural Health

In cooperation with the Better Health Council of Georgia, Chairman George H. Alexander, Forsyth, held an expeditious meeting of the Rural Health Committee which adopted a three-phase program to (1) provide more general practitioners and better distribution of physicians throughout Georgia, (2) to educate physicians of the state on rural health needs; and (3) support the accident prevention program of MAG and the State Department of Public Health, etc. Other projects are being investigated, and the committee scheduled its next meeting for November 11.

Journal OF THE MEDICAL ASSOCIATION OF GEORGIA

The Use of the Routine Vaginal Smear as a Screening Test for Uterine Carcinoma

JAMES H. McCLURE, M.D., WILLIAM L. CATON, M.D., and GENEVIEVE LUCCHESI, A.B., Atlanta, Georgia

THE USE OF THE "ROUTINE" vaginal smear is not generally accepted by the clinician even though the practice of obtaining a cervical and/or endometrial biopsy from a patient with a suspicious history or pelvic lesion and obtaining routinely a vaginal smear from a patient with a negative history and examination should provide the "ideal" method of detecting pelvic malignancy. A personal survey of the vaginal smear in the greater Atlanta area found that only one gynecologist in private practice obtained a routine vaginal smear from each patient regardless of the patient's age or complaint. Of the men who were queried, a majority obtained a smear on definite (and varied) indications. Some physicians did not do vaginal smears.

Reasons for the Clinician's Failure to Accept Smears

As regards carcinoma, the question foremost in the physician's mind is: "Does the patient have cancer¹¹?" The practicing gynecologist knows from clinical experience that a biopsy taken from an area that appears abnormal (clinically suspicious) will reveal a certain number of patients with cervical cancer. Examination of the voluminous cytologic literature, however, finds that only rarely has the cytologic investigator answered satisfactorily either of the clinician's two foremost questions about the value of the vaginal smear in diagnosing clinically unsuspected uterine malignancy. These questions are: 1) how many patients with *unsuspected* cancer may be correctly diagnosed if the routine vaginal smear is employed and: 2) how many patients with unsuspected cancer will be missed using the smear. In Table I are tabulated the results of studies by several cytologic investigators. The percentages ap-

pearing in the table were calculated as accurately as possible from the references cited.

There is, in addition, an often whispered, never written, inherent skepticism by the clinician of a method (cytologic) which may permit the same person to simultaneously interpret a vaginal smear and diagnose a histologic section. This skepticism is enhanced by papers which cite statistics obtained by making use of the cytologist's histologic diagnosis in cases where the cytologist and the pathologist disagree on the diagnosis of the histologic sections.²⁰ Nor has the cytologic cause been furthered by the use of the vaginal smear to confirm the diagnosis of histologically proven malignancy.⁴

The implication that vaginal smears may play a major role in helping the physician to arrive at a correct diagnosis of patients who have somewhat atypical appearing cervical lesions,¹⁹ postmenopausal bleeding,^{6, 13, 12, 14} recurrent postmenopausal pyometria,¹³ meno or metrorrhagia,^{13, 16} histologically proven ovarian cancer with uterine bleeding,¹³ and cervical polyps¹³ is unwarranted. The physician should suspect cancer in this heterogeneous group of patients and therefore do multiple cervical biopsies and/or dilatation and curettage.

Unfortunately, the physician who sees the patient has contributed to the inability of the cytologic investigators to correlate the patient's history and physical findings with the cytologic interpretation and histologic diagnosis. Letters asking for clinical information or follow-up often go unanswered.

Purpose of This Investigation

The purpose of this investigation was to determine more accurately the prevalence of uterine carcinoma in patients seen on the Gynecologic Service of Emory University at Grady Memorial Hospital, Atlanta,

* From the Department of Obstetrics and Gynecology, Emory University and Grady Memorial Hospital, Atlanta, Georgia.

<i>Investigator & Reference</i>	<i>Total Pts.</i>	<i>No. Dx'd. Only By Smear</i>	<i>Total Prevalence (Histo Proven)</i>	<i>Length Study</i>	<i>Source of Pts.</i>
Fremont-Smith (7)	704	?	1.3%	4 yrs.	Pvt. Internist's Office
Graham (8)	18,303	.4%	4.6%	9 yrs. (43-51)	Diverse (Vincent Memorial)
Anderson (2)	3,000	1.1%	1.7%	3 yrs. (50-53)	Selected Clinic Population Edinburgh
Wachtel (20)	2,550	.19% ?	2.1% ?	2 yrs. (50-51)	All Gynecologic Out & In Pts. over age 30, Post Grad. Med. Sch., London
Allan (1)	5,949	.5%	.7%	6 yrs. (49-55)	90% from Pvt. Gyn. Office Springfield, Mass.
Rogers (17)	13,797	?	.8%	1 yr. 1953 (?)	Cytologic Diagnostic Center, Miami, Florida
Ayre (3)	5,278	.9% ?	1.69%	14 mos. (51-52)	Pvt. MD's Dade County, Florida
Haynes (10)	6,816	.53%	1.64%	3 yrs.	All Gyn. Cl. Pts. + OB Pts. & Hospital Personnel, Dallas, Texas
Parrett (15)	1,000	.40%	2.90%	9 mos.	New Gyn. Clinic Pts. Los Angeles
Botsford (5)	3,000	.30%	2.20%	3 yrs. (46-49)	All Gyn. Out-pts. & All (?) Surg. In-pts., Mass. Gen. Hosp.
Skapier (18)	7,777	.27%	.27% ?	2 yrs.	"Asymptomatic" Pts. Strang Cancer Prevention Clinic

Table I
Prevalence of Pelvic Carcinoma Found by Various Investigators*

Georgia, and to compare the "routine" vaginal smear method of screening for carcinoma of the uterus with the "biopsy on clinical suspicion" method which is in use on the service.

Population Served

The population group seen on this service lives in two counties and is predominately indigent urban Negro. The number of female patients eligible for medical care in this clinic is not known accurately. No charge is made to any patient for any medical care rendered by the hospital. For practical purposes no other medical care is available to this group of patients.

Procedure

A cervical scraping obtained by means of a wooden tongue blade was obtained from each patient seen in the gynecologic out-patient clinics during a one-month period. The scraping was spread on a glass slide which was identified by the date and clinic number, and the slide was placed immediately in a 50:50 solution of ether: 95% ethyl alcohol. Staining was done using a modified Papanicolaou technique, and the slide was cover-slipped with a 22 x 40 mm.

coverslip. All slides were screened and interpreted by the same observer (J.H.M.) and classified into one of two categories: "benign" or "malignant." No clinic or histologic information was available when the slide was interpreted.

Follow-up studies, when obtainable, included sequentially: 1) a Shiller test and a four quadrant cervical biopsy of those patients whose smear was interpreted as "malignant" and 2) cold-knife cervical conization and dilatation and curettage of the patients whose biopsy was not diagnosed as showing invasive carcinoma.

Prior to the interpretation of the smear the patient was managed as though the vaginal smear had not been taken.

All histological sections were diagnosed by the Department of Pathology. In this particular Pathology Department the entire tissue removed by conization is divided into 12 to 20 blocks (depending on the quantity of tissue). Sections from each of the blocks are examined microscopically. The criteria used to make a diagnosis of insitu carcinoma of the cervix are the generally accepted ones.

* The percentages in this table were calculated as accurately as possible from the references cited, and do not necessarily appear in the reference.

Results

A total of 670 different patients was seen during the one month period. Of these patients, 452 were Negro and 218 white. Forty of the 670 smears were interpreted as "malignant."

During the period covered by this study, 84 patients had a four quadrant, cervical, forceps-biopsy done because of "clinical suspicion." Ten of these 84 biopsies were positive (five invasive carcinomas of the cervix and five in situ carcinomas of the cervix). The smears of nine of these 10 patients with malignancy had previously been interpreted as "malignant."

A vigorous attempt was made to obtain follow-up examinations on the remaining 31 patients who almost without exception had no return appointment to the clinic. The difficulties encountered in obtaining follow-up studies in this group of patients form the basis of a separate report. Table II lists the results of the Shiller tests and four quadrant cervical biopsies obtained from 27 of the 31 patients. The results of cervical conization and dilatation and curettage are tabulated in Table III. Table IV compares the number of patients found with carcinoma by biopsy on

"clinical suspicion" with the number of patients with carcinoma diagnosed solely because of the "routine" vaginal smear.

Discussion

Prior to this study, "routine vaginal smears were not available to this group of patients. Vaginal smears taken during the one month period were directly responsible for diagnosing two cases of unsuspected invasive carcinoma of the uterine cervix and six unsuspected cases of insitu carcinoma of the cervix. The study shows that in this clinic the addition of a "routine" vaginal smear to the patient's diagnostic work-up may yield as many as 100 additional patients with pelvic malignancy per year. And this with a follow-up that is grossly inadequate.

The division of smears into only two groups is not entirely satisfactory, but this classification was made to make the method as specific as possible. Although the recognition of "pre-malignant" lesions is extremely important from the investigation viewpoint and as an aid in determining the frequency of follow-up examinations, the pre-malignant smear has no immediate therapeutic application.

Correct cytologic interpretation is obviously limited by the ability of the cytologist. The slides obtained from the Negro clinic were difficult to interpret since they were almost without exception of the "dirty" type (polys, debris, etc.), in contrast to the slides from the white clinic. The small number of cervical conizations and curettments done in this series of patients makes impossible a calculation as to the specificity of the method in our hands. The one patient with in situ carcinoma diagnosed by biopsy on "clinical suspicion" and missed on examination of

Patient	Age	Race	Shiller Test	Diagnosis
1) E.B.	42	W	—	Chr. Cervicitis.
2) E.Y.	16	N	+	Marked squamous metaplasia; fairly marked loss polarity.
3) F.G.	27	N	+	Ca. in situ (?); recut of blocks: Ca. in situ.
4) G.A.	17	N	+	Ca. in situ (?).
5) W.W.	20	N	—	Ca. in situ with (?) invasion.
6) S.W.	21	N	—	Ca. in situ.
7) D.S.	37	N	—	Ca. in situ (?).
8) L.A.	27	N	+	Chr. cervicitis, sq. metaplasia, hyperchromatism, sl. loss polarity.
9) P.H.	14	N	—	Chr. cervicitis.
10) M.M.	25	N	—	Cervical tissue.
11) Z.G.	25	W	—	Ca. in situ.
12) L.L.	38	N	+	Adenocarcinoma.
13) L.C.	36	N	+	Sq. Metaplasia.
14) R.S.	35	N	+	Chr. cervicitis, one suspicious area, requested rebiopsy.
15) H.D.	57	N		Cervical tissue, some cellular unrest basal layers.
16) M.C.	15	N		Chr. cervicitis, advised more generous biopsy.
17) B.F.	37	N	+	Cervical tissue.
18) M.H.	24	W	—	Chronic cervicitis, sq. metaplasia.
19) R.R.	19	N	+	Chr. cervicitis, loss polarity 1 area, advise rebiopsy.
20) M.L.C.	30	N	+	Normal cervix.
21) D.S.	24	N	—	Ca. in situ (?).
22) N.D.	37	N		Decidual reaction.
23) I.J.	16	N	+	Chronic cervicitis with marked acanthosis.
24) L.C.	26	N	+	Chronic cervicitis.
25) R.C.	35	N	+	Ca. in situ (?).
26) G.J.	52	N	+	Chr. cervicitis with lymph follicle infiltration.
27) W.S.	18	N	—	Ca. in situ.

Table II

Results of Four Quadrant Cervical Biopsy Following "Positive" Vaginal Smear from "Clinically Negative" Cervix

Patient	Diagnosis
1) E.B.	Squamous metaplasia.
3) F.G.	Sq. cell carcinoma.
10) M.M.	Ca. in situ.
11) Z.G.	Ca. in situ.
13) L.C.	Chr. ulcerative cervicitis.
18) M.H.	Chr. cervicitis, marked metaplasia & loss of polarity.
25) R.C.	Extensive ca. in situ.

Table III

Results of Cervical Cold Knife Conization

Total Number of Patients with Histologically Proven Carcinoma	18
Diagnosed by biopsy on clinical suspicion	10
In situ carcinoma of the cervix	5
Invasive carcinoma of the cervix	5
Diagnosed solely because of cervical smear	8
In situ carcinoma of the cervix	6
Invasive carcinoma of the cervix	2

Table IV

Comparison of the Number of Patients with Carcinoma Diagnosed by Biopsy on "Clinical Suspicion" with the Number of Patients with Carcinoma Found Solely Because of the "Routine" Cervical Smear

the vaginal smear had a type of smear not previously encountered in this laboratory.

It is interesting to note that patient number 10 (M.M.) would have been incorrectly diagnosed had conization not been done. Biopsy of the benign appearing, cytologic positive cervix may be done without hospitalization but immediate conization is a more completely satisfactory diagnostic procedure.²⁰

It is significant that five of the six patients with carcinoma in situ diagnosed because of the vaginal smear were under 26 years of age. This compares with no patients under age 26 in the in situ group diagnosed without the aid of smears.

No explanation is offered for the higher incidence in this study of malignancy found in the Negro patients when compared with the white patients.

In presenting this series of patients a four month period of follow-up was arbitrarily selected. A biopsy taken as long as or longer than four months after a smear may or may not reflect accurately the patient's status at the time when the vaginal smear was obtained.

Summary

Seven patients with invasive carcinoma of the cervix and 11 patients with in situ carcinoma of the cervix were discovered in the 670 different patients seen during a one month period in the Gynecologic Out-patient Clinics of Emory University at Grady Memorial Hospital, Atlanta, Georgia.

Of these 18 patients with clinically unsuspected invasive carcinoma and six patients with clinically unsuspected in situ carcinoma of the cervix, were correctly diagnosed solely because of the examina-

tion of a "routine" Papanicolaou spread obtained by cervical scrapings. Five of the six patients with clinically unsuspected in situ carcinoma of the cervix were under 26 years of age. Only one of the six patients with unsuspected in situ carcinoma of the cervix had a positive Schiller test.

69 Butler St., S.E.

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New MAG Members

Name	Address	Classification	County
Claude Lee Pennington	1161 Nottingham Drive, Macon	Active	Bibb
William H. M. Weaver	700 Spring Street, Macon	Active	Bibb
Robert Miletus Wynne	2305 Ingleside Avenue, Macon	Active	Bibb
Grady F. Duke	Scott Street, Buford	Active	Chattahoochee
John A. Cauble	Jarvis Street, Canton	Active	Cherokee-Pickens
Wells Riley	110 McDonough Street, Jonesboro	Active	Clayton-Fayette
James Wiley Reynolds	Goss Clinic, Ashburn	Active	Flint
John R. Bottomy	Emory University Hospital, Emory University	Active	Fulton
Alexander Denholm Milligan	9 Althea Parkway, Savannah	Active	Ga. Med.
Mark W. Wolcott	VA Hospital, Augusta	Active	Richmond
Homer P. Wood	Clay County Hospital, Ft. Gaines	Active	S. W. Georgia
Ralph Hill Chaney, Jr.	304 North Sage Street, Toccoa	Active	Stephens
Carter Lee Meadows	Jesup-Wayne County Hospital, Jesup	Active	Wayne
Frederick Lawrence Russell	621 McCamy Street, Dalton	Associate	Whitfield

The Best Insurance Against Depression

ROBERT SCHARF, Ph.D., Atlanta, Georgia

THE RECOGNITION that all Americans sail in the same economic ship is growing. It makes us realize that no individual has a right to actions which would serve his personal selfish interests, but at the same time endanger the safety of the whole ship and of everybody on it. Our whole education for good citizenship is a sincere attempt to strengthen the individual's sense of social responsibility which means response to duties toward one's society.

However, it would be naive self-deceit to believe that this sense of social responsibility could eliminate our "profit motive." Whenever a person makes an investment he certainly thinks first of the good it will do him. But it probably will make him feel good and important if he will have the patience to go on and read this article.

Let us assume that you decided to add another room to your house at an expense of \$1,000. Carpenter B, then, will receive your \$1,000. Let us further assume, just for the sake of expounding an economic theory, that carpenter B will keep $\frac{1}{3}$ of your thousand dollars and spend $\frac{2}{3}$ for the needed raw materials. Therefore C, the seller of the necessary timber, will receive \$666.67. Now, C will keep $\frac{1}{3}$ of this money and will spend the other $\frac{2}{3}$ or \$444.44 for a refrigerator his wife wanted so badly. The refrigerator man, D, will keep $\frac{1}{3}$ of this money and will spend the other $\frac{2}{3}$ or \$296.30 for some consumption goods he buys from E. E will save $\frac{1}{3}$ and spend the other $\frac{2}{3}$ or \$197.53 for something he badly needs or wants, and so on.

In other words, with your investment of \$1,000 you have started a chain of sequent investments which, of course, become smaller and smaller until they reach zero. However, if you would add up all the purchases caused by your initial investment of \$1,000, you would discover that these thousand dollars caused sales transactions in the amount of \$3,000. Now, you are aware that your investment caused the national income to expand threefold.

This amplification of individual investments in relation to national income is called the "Multiplier Doctrine" and proves how high-powered investment dollars are.

The significance of this multiplier effect on our national economy, on the seaworthiness of the economic ship all of us are sailing in, becomes obvious.

Technological inventions result in the creation of new corporations which need money to produce them and therefore issue stock. Thus, they create new investment opportunities for anybody with savings on hand. But this also means that the American investors who buy for ten billion dollars new stock automatically create thirty billion additional dollars income to others. It does not require much economic background to understand that these newly created thirty billion dollars will enable many a business man and industrialist to expand his own business or plant by placing additional orders. Thus, each additional dollar invested immediately grows into three dollars of previously not existing purchasing power. Under the theoretical assumption that always one third will be saved and two thirds spent and available for new consumption, this increased consumption will put previously unemployed people to work and in turn enable them to spend and to save. In this way, soon full employment is achieved: everybody on our ship can work, consume and save.

If we assume that instead of two thirds three fourths of available money will be spent and one fourth saved, the principle involved would result in a proportional multiplier effect, so that \$1,000 would create \$4,000 of sales transactions.

Of course, if for any reason, for instance in expectation of a bearish market with falling stock prices, the average investor should prefer not to invest, he would hoard his savings because he is afraid he may lose them. What will happen, then?

A thousand dollars not invested but kept "safely" at home will—under the reverse effect of the multiplier doctrine—reduce spendable income of others by \$3,000—as we have seen before in the case of investment with confidence in our economy, where these \$1,000 have trebled. Projected on national dimensions, ten billion dollars needed for investment but not provided will immediately weaken the American economy at the rate of thirty billion dollars. The enterprises which would be accordingly restricted in their sales would have to abstain from replenishing their inventories. As a logical consequence the factories with decreasing orders would have to reduce their work forces. Unemployment with its snowball effects would affect the general purchasing power. And the dreaded recession or depression has arrived.

The moral of the multiplier doctrine? The investor who expresses his confidence and belief in the seaworthiness of our American economic ship and, therefore, buys regularly stock to provide the needed capital for expansion should not think only of the big profit he himself is going to make. Even if the profit should not materialize as high as it was anticipated, the knowledge of the multiplier effect his in-

vested dollar is creating should have a positive effect on his own thinking. It should remind him that not-investing is somehow similar to endangering the seaworthiness of his economic ship. But if he invests in promising stock, he becomes a dutiful and conscientious crewmember on that proud economic ship called "U.S.A."

Georgia Institute of Technology

Sears-Roebuck Foundation Grants

THE SEARS-ROEBUCK FOUNDATION, in cooperation with the American Medical Association, has a plan for assistance in establishing medical practice units with loans of up to \$25,000. The unsecured, low-cost, 10-year loans are available to physicians seeking to establish new practices but unable to arrange full local financing.

The plan requires that the physician first exhaust all local possibilities for financing, that his application indicate a need for a practice in the proposed locality and good possibilities for success and public service, and that he give evidence of effort and thought in planning a well-organized, effective practice unit. Contributions made by the grantee in repaying the grant will be turned back into the fund for the establishment of further units, thus providing what the foundation calls "built-in chain reaction." The plan also features advantages encouraging early repayment of grants to speed up establishment of more units.

The foundation states that its plan is intended to "realize the principles of opportunity, incentive, mutual help, and self reliance; to give the American people the best possible medical care, and to help the American physician build for himself the most effective, the most rewarding and the most satisfying life as a professional man." Continuation of the plan depends on support by the medical profession. The plan relies on individual initiative and enterprise, requires that assistance be given only where it will generate independence, and is sustained entirely by those who benefit from it.

Besides making unsecured 10-year loans to physicians seeking to establish practices, the Sears-Roebuck Foundation, after consultation with the American Medical Association, has prepared a brochure as a *Planning Guide for Establishing Medical Practice Units*.

The brochure may be borrowed from the office of the Medical Association of Georgia, upon receipt of a written request. It was financed by a grant from the Sears-Roebuck Foundation and developed with the guidance and advice of a medical advisory board appointed by the American Medical Association.

It provides information for physicians setting up practices, expanding practices, or combining with other physicians to develop single medical units. Community leaders who are planning medical units in order to attract physicians to their towns will also find the brochure of interest and assistance.

The eight basic elements in the planning of any unit are described: 1. the reception room, 2. the receptionist-control-station business office, 3. the consultation room, 4. the examining and treatment room, 5. the laboratory (including electrocardiographic and metabolism apparatus), 6. the x-ray and diagnostic room, 7. the lavatory, and 8. the utilities and storage room.

Drawings and explanations of each element, along with examples of how these various elements can be combined and expanded, are presented.

Specific aspects, involving heating, ventilating, air conditioning, plumbing, and wiring are also discussed.

Actual management of practice, once the medical unit has been established, is considered in another section. Types of organization, division of income, retirement, sick benefits, death benefits, and settlement of estates are some of the subjects covered.

If you wish to borrow a copy of this pamphlet, address a request to the headquarters office at 875 West Peachtree St., N.E., Atlanta 9, Ga.

In the short time the fund has been in existence, 22 loans have been made affecting 33 physicians from 13 states. Loans ranged from \$3,000 to \$25,000, and total loans amount to \$179,500. Loans have gone to general practitioners, specialists, partnerships and medical groups. The sole criterion, besides medical proficiency, has been the need of the community for medical care.

In 1956 it was necessary to have two cut-off dates in processing applications—April 1st and October 1st. Applications received before October 1st shall be acted upon by December 15th. The Foundation is now accepting applications for the last half of 1956.

Treatment of Segmental Arteriosclerotic Occlusive Disease of the Lower Extremities

MILTON F. BRYANT, M.D., Atlanta, Georgia

PERIPHERAL ISCHEMIA is frequently caused by arteriosclerotic occlusions which are segmental in nature. The vessel above and below the occluded area may be free of, or minimally involved with, atherosclerosis.¹ J. Cid dos Santos² first made direct clinical use of these findings by reaming out the occluded area through short incisions made in the vessel wall—thromboendarterectomy. Reboul³ modified this procedure by advising a longitudinal incision through the vessel wall over the entire length of the thrombosed area. The thrombosed atherosclerotic intima and necrotic inner media were then reamed out so as to re-establish blood flow through the occluded segment. Thromboendarterectomy has been moderately successful in restoring a patent lumen to some of the larger peripheral vessels; however, the success of Gross and his associates⁴ in 1948 in using aortic homografts to restore functional continuity to the thoracic aorta, following resection of coarcted segments and to establish aorta-pulmonary artery shunts, stimulated great interest in using homografts to replace damaged or diseased segments of arteries. The successful use of autogenous, fresh, and freeze-dried homografts has been reported on many occasions. Difficulty in obtaining, processing, and storing homografts plus the knowledge that the graft per se does not survive⁵ has stimulated efforts and interest in using various artificial prostheses as vessel substitutes.^{6, 7} It is likely that substitute materials of completely nonbiologic origin will replace freeze-dried homografts as the most popular and satisfactory arterial substitute in the near future. The by-pass procedure as described by Kunlin⁸ awaits evaluation; however, preliminary experience seems promising.⁹

The following cases are examples of atherosclerotic segmental arterial occlusions which were treated by re-establishing the continuity of the artery.

Case 1

E.B., a 35 year old white sergeant was admitted to the

From the Whitehead Department of Surgery, Emory University, and the Grady Memorial Hospital.

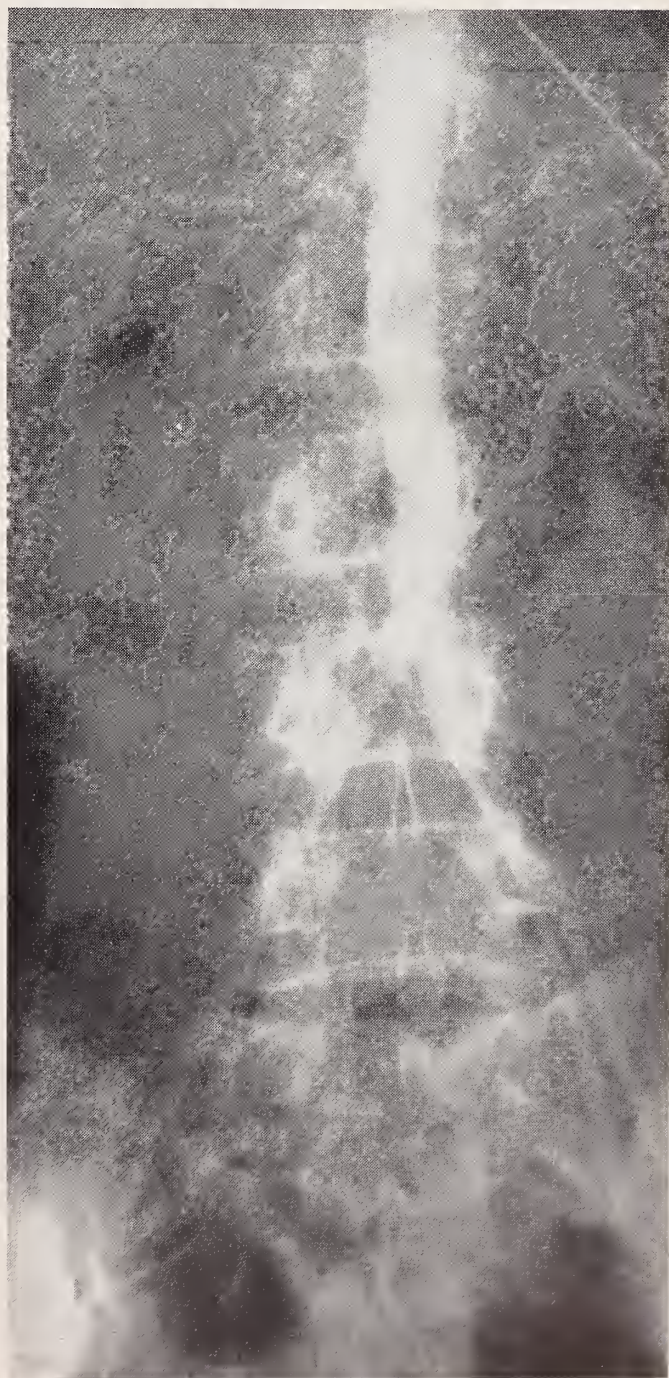


Figure 1
Normal percutaneous aortogram.

hospital complaining of pain in his low back region and upper legs. While walking at a fair six months prior to admission, he noted sudden pain in both hips. The pain gradually subsided; however, shortly thereafter he noted dull, cramping pains in both thighs and low back region if he tried to walk over three or four blocks. For four months he had noted progressive decrease in libido and inability to sustain an erection.

Physical examination was essentially normal with the exception of the lower extremities. No pulse could be palpated in either leg. No atrophy of the skin or leg muscles was detected. Elevation pallor or dependency rubor was not present. The neurological examination was normal.

Routine laboratory studies were normal. The total blood cholesterol was elevated to 350 mg. per cent. Translumbar aortography (Figure 2) was carried out, and complete blockage of the terminal aorta was noted. The obstructed bifurcation was resected and continuity restored with a homograft. Postoperatively good pulses were present in both feet and the claudication disappeared. He is now able to sustain an erection.

Case 2

For a year prior to admission this 55 year old sergeant had noted cramping pains in his left calf and thigh region. The cramping pains became progressively severe and at the time he was admitted to the hospital he could not walk over two blocks without developing pain. Recently his left foot had become sensitive to cold and for this reason he avoided activity that required him to be outside in the winter months.

The general physical examination showed moderate obesity. Blood pressure was 140/90 and examination of the heart

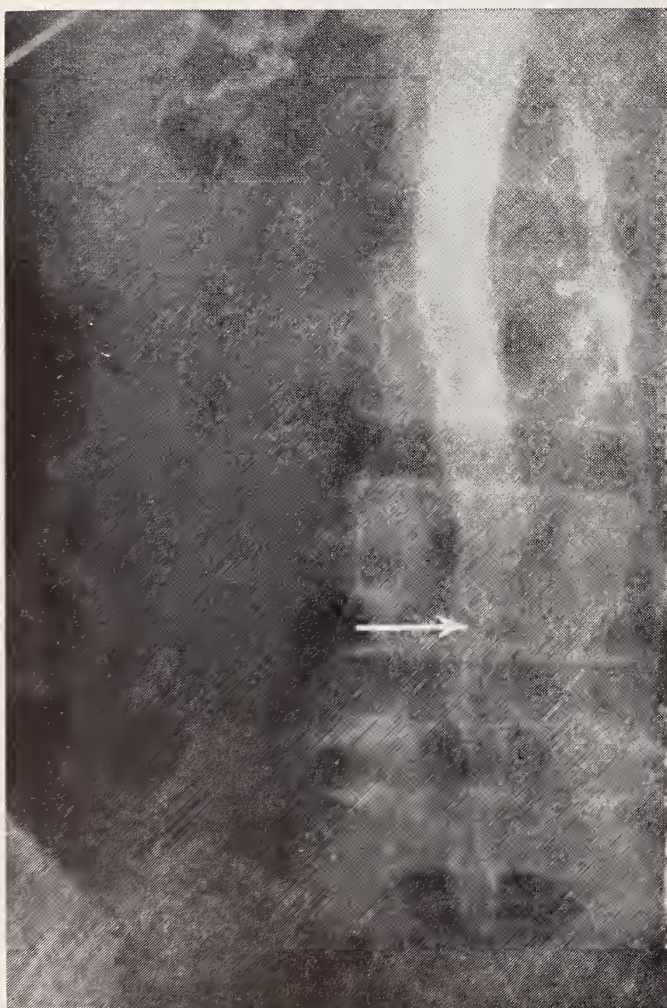


Figure 2

Aortogram carried out under local anesthesia, showing block of terminal aorta-Leriche syndrome



Figure 3

Aortogram showing segmental block of left external iliac artery.

and lungs was essentially normal. A normal abdominal aortic pulse could be palpated. Pulses could not be palpated in the left leg. Normal pulsations were present in the right lower extremity. The left foot was cooler than the right, and increased sweating was noted over the lower left leg and foot. No color changes were noted on elevation or dependency in either leg. Normal toe pads were noted in the left foot.

Routine laboratory studies were normal. A translumbar aortogram (Figure No. 3) done under local anaesthesia revealed a segmental block of the left external iliac artery. Following excision of the thrombosed segment, a fresh arterial homograft was used to restore vessel continuity. Lumbar sympathectomy, removing ganglia L2, L3, and L4 was also performed. Postoperatively the patient has good peripheral pulses in his left leg and is able to walk without claudication.

Case 3

This 46 year old Air Force captain complained of a tired feeling in his left foot and left calf if he walked one block. He stated that he first noted difficulty with walking approximately nine months previously and his walking ability had been progressively restricted. At the time of admission to the hospital, he could walk only one block before developing a "painful, tired feeling" in his left foot.

Physical examination revealed the blood pressure to be



Figure 4

Femoral arteriogram showing segmental occlusion of superficial femoral artery. Note filling of the popliteal artery.

150/95. The patient was an asthenic white male officer who appeared older than his stated age. The general physical examination was essentially normal with the exception of the left leg. The left femoral pulse was palpable but markedly diminished in intensity. The left leg was cooler than the right, and typical elevation pallor and dependency rubor were noted. The toenails showed nutritional changes; however, the fat pads of all the toes were well preserved.

A translumbar aortogram (Figure 4) was carried out under local anaesthesia and blockage of the entire left superficial femoral artery was noted. The popliteal artery was noted to fill.

An autogenous vein graft was used to restore vessel continuity after the thrombosed left superficial femoral artery had been excised. Considerable atherosclerosis was present in the vessel at both suture lines. A left lumbar sympathectomy was carried out as a preliminary procedure removing ganglia L1, L2, and L3. Immediately postopera-

tively the patient did well, but two months postoperatively thrombosis of the graft occurred which was proved by an arteriogram. The patient still has limitation of walking ability and is not improved over his preoperative condition. He is being re-evaluated for possible re-grafting.

Case 4

This 55 year old white woman complained of pain in her left foot if she walked for any distance while doing her shopping. If she continued walking the pain would extend to the left calf region; by stopping for a few minutes the pain would go away. She had had a diagnosis of thrombophlebitis made on several occasions.

The essential findings on physical examination were limited to the lower extremities. Normal femoral pulses were present bilaterally. A good popliteal pulse was present on the right. No pulses were palpable distal to the femoral triangle in the left leg. Mild elevation pallor and dependency rubor were noted on the left. The fat pads of all the toes



Figure 5

Femoral arteriogram showing a short segmental arteriosclerotic occlusion in the superficial femoral and proximal popliteal arteries.

were well preserved; increased sweating of the left foot was noted.

A left percutaneous femoral arteriogram was carried out under local anaesthesia using 35% diodrast. A segmental block of the distal left superficial femoral artery was noted.

Subsequently the segmental block was excised, and continuity was restored by using an autogenous vein graft obtained from the proximal portion of the right great saphenous vein. A left lumbar sympathectomy was also carried out removing ganglia L2, L3, and L4. Postoperatively, normal pulses were noted in the left foot and the patient has been relieved of her claudication.

Comment

These cases illustrate the problems which are frequently encountered in patients with peripheral ischemia due to arteriosclerosis. Since arterial continuity can be restored in many of these patients, the importance of performing routine arteriograms in all patients who have pulses absent at the femoral or popliteal regions should be stressed. It is felt that the colloidal iodine solution should not exceed 35% for femoral arteriograms. This procedure can be satisfactorily carried out under local anesthesia. If pulsations are absent in the femoral region, a translumbar aortogram should be performed. In many instances, aortography may be carried out under local anaesthesia. Urokon® 70% is the contrast medium of choice for aortography. If the popliteal artery is found to be patent, restoration of vessel continuity by grafting may be possible. Obstructions below the bifurcation of the popliteal artery are best treated by lumbar sympathectomy, along with the usual conservative measures.

Most segmental arterial occlusions occur in the superficial femoral artery, and successful restoration of vessel continuity is more difficult in this area as

compared to obstructions in the terminal aorta and the iliac arteries. It would seem desirable to perform sympathectomy, along with grafting, in patients who have segmental superficial femoral arterial occlusion as a certain percentage of these grafts will thrombose weeks to months following surgery. The by-pass procedure as originally described by Kunlin,⁸ and more recently by Crawford⁹ and associates, may prove to be the treatment of choice for patients with long segmental occlusions in the femoral artery.

Summary

Patients with arteriosclerotic peripheral vascular disease frequently have segmental occlusions which may be amenable to surgical correction. Arteriographic studies should be carried out earlier and more frequently. To place these patients routinely on a conservative medical program may lessen their chances of having arterial continuity restored at a later date.

1211 West Peachtree St., N.E.

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Can Stress Trigger Infections?

DR. RENE J. DUBOS, one of the world's great bacteriologists and a pioneer in antibiotic research, is at present engaged in experiments at Rockefeller Institute which suggest that physiologic and sociologic disturbances are as important as germs in causing infections.

Improper diet, emotional disturbances, war and inflation, metabolic imbalance or the introduction of drugs may so alter the tissues of the body, his experiments indicate, as to trigger into virulent action pathogenic germs that have long been present in a passive state.

"Let me speak of one specific experiment," he said. "A very good diet is fed and there is normal resistance to tuberculosis. After two days, replace the good diet by a very bad diet. The mere disturbance will make the animal more susceptible to TB.

"Any number of transient disturbances can upset your resistance today and create a situation in which infection can become active. Incidentally, statistics indicate that tuberculosis mortality increases during a war and reverts to normal when peace is declared. Similarly, statistics indicate that disease increased during the German currency inflation after World War I and went back to normal when the currency was stabilized.

"I wish to show with some biochemical and physiologic exactitude that war, social disturbances, personal emotional stress, result in tissue changes which create a favorable environment for pathogenic germs, germs which may have been present in the host for years, comparatively harmless until the introduction of disturbance."—From *Scope Weekly*.

Mistakes, Omissions and Surprises in the Care of Chest Diseases

F. LEVERING NEELY, M.D., Atlanta, Georgia

IN THE CARE OF ALL DISEASE, we find that our clinical judgment is often faulty. As doctors, we are prone to small and sometimes significantly large errors in the care of our patients. In spite of the tremendous advances in the laboratory science of clinical pathology, it is still easy to misinterpret and to overlook. In treatment, we may over-treat or undertreat. Medicines and procedures improperly used may have disastrous effects. It is our duty to be constantly aware of these errors if we are to practice good medicine. Often we never know of our mistakes.

Chest disease is a field in which it seems that confusions are very common. So many of the chest diseases resemble each other or are atypical. Textbook pictures are misleading at times. In the last few years we have made many errors and seen others make them. We felt that if we could collect and classify some of these errors it might help us in the future.

History taking is most important. Failure to elicit some apparently small fact may alter the entire course of a disease. Unnecessary operations may be performed because of a poor history.

An example of this we see in the *New England Journal of Medicine* in the case record of a patient with what appeared to be masses in the mediastinum. After a complete and thorough work-up, including bronchoscopy, exploratory thoracotomy and resection was done. The diagnosis made from the specimen was lipoid pneumonia. After operation, the history obtained disclosed the fact that the patient had been using oily nose drops for 24 years. This patient may have required operation in any event due to the suspicion of cancer, but in other cases it might not. Lipoid pneumonia is one of the commonly overlooked diseases.

Another example was that of a patient who had a high fever, cough, headache, and signs of a virus pneumonia. We sent this patient to the hospital without taking an adequate history. The intern obtained the history that she had been exposed to a sick parakeet two weeks previously. The agglutination test for psittacosis was positive.

In history taking most of the errors seem to be in the nature of poor or inadequate history.

Sometimes in our zeal we tend to make more history than is really there. It may be in the nature of leading the witness. The patient unintentionally may fall right in with the doctor's questions. One such was a 59 year old colored man who had a small right pleural effusion and an unknown infiltration. The intern developed a fine history of aspiration two weeks before. He admitted drunkenness, awoke from a sleep coughing and gagging. His case was considered as possibly non-tuberculous until the culture of the pleural fluid came back positive for acid fast bacilli.

Physical signs are frequently misleading. One of the most commonly missed diseases is spontaneous pneumothorax. The breath sounds, contrary to the textbooks, may come through very well. Pneumonia, particularly in the upper lobe, is missed often. Tuberculosis, even with huge cavities, presents so few physical signs that many a phthisiologist is tempted to dispense with the stethoscope entirely. Other chest lesions missed are atelectasis and partial bronchial obstruction. The only symptom of the latter may be a localized wheeze.

Examination of the chest with the stethoscope may become so routine that one tends to become absent-minded. We are often brought up sharply by the x-ray and go back and listen to signs that were missed on the first examination.

Laboratory errors and x-ray errors are a little easier to analyze, and perhaps we can see what may be done to prevent them. The pitfalls of the Papanicolaou stain are well known.

One of the most glaring and inexcusable errors having to do with the laboratory is simple failure of a report to find its way to the chart or failure to recognize the significance of a report. I, personally, have seen several patients who were admitted to a hospital with various pulmonary diagnoses and who were discharged before the sputum report was back. A positive sputum would come back six weeks later. The interns would change services and somehow the report would not be followed up. I would hesitate to go into this simple failure if it had not happened so often. The remedy is for the laboratory to call the doctor directly on any newly positive culture.

False positive sputa for tuberculosis are fairly common. Typical acid fast bacilli may be seen on smear and yet culture remains negative. There are numerous non-pathogens found in water, butter, and smegma. One must remember that the culture is the only dependable report. Non-pathogens usually are bright yellow on culture and easily differentiated from true tubercle bacilli. False negative sputa may occur when there is bronchiectasis as well as tuberculosis. The cultures may be over-grown with pyogenic bacteria. Sometimes patients with hemoptysis are negative while bleeding from large open cavities.

The x-ray in chest disease is full of difficulties. A great deal of reliance is placed on x-ray and rightly so, but a great many errors in treatment have been based on faulty interpretation of x-rays. One often fails to see a lesion on a routine film and then sees it in retrospect. Lesions hidden behind a rib or the clavicle are overlooked. The remedy is to read a film by a system and compare each side carefully. Spot films of apex and stereoscopic films may help.

Improper technique in films may make it appear that a patient is better or worse; an over-exposed film makes it appear that the patient has improved when this is not the case. The tomogram is an excellent method of showing cavities and of showing lesions not visible in the plain film, but it may show a cavity or a lesion that is not present. A patient may be operated upon because a new lesion is seen by tomogram, and the lesion may not be present at all.

Procedures may produce unintended reactions. It is said that there have been several fatalities from bronchograms in Atlanta in the last few years. Sensitivity to cocaine is very common. It is mandatory that barbiturates be given before cocainizing, and that intravenous barbiturates be on hand. Sensitivity to iodine should be checked. Patients with poor vital capacity should not have bronchograms done.

Air embolus may occur during pneumoperitoneum

and pneumothorax. One should be ready to turn the patient on the left side and to have 100% oxygen ready for use. During thoracentesis, the lung may be punctured and cause a traumatic pneumothorax or air embolus. In blocking intercostal nerves in pleurisy, it is also easy to puncture the lung. One such case with asthma had a traumatic pneumothorax and died.

In treatment one must be constantly on the alert for errors of all kinds. Watching a lesion may be fatal to the patient if it is carcinoma. The problem of the round infiltrate has reached the state that most chest surgeons are removing them regardless of size or length of time present. Even calcium in the lesion does not mitigate against surgery.

Hemoptysis in tuberculosis is an acute emergency and not recognized as such. A minimal lesion with hemoptysis may cause spread to far-advanced disease in a short time if not given immediate bed rest and chemotherapy. Morphine given to patients with massive hemoptysis may cut down the cough reflex to such an extent that the patient may drown in his own blood.

One is often faced with the decision of whether or not to treat a patient with a pleural effusion as tuberculosis when no organisms are found. The untreated cases with tuberculosis have a high mortality. Failure to treat such patients for economic reasons is highly dangerous.

Finally, one of our common errors is failure to take sufficient time to explain to the patient all of the aspects of his disease. There are many patients who sign out of hospitals unnecessarily because of insufficient explanations as to operations and procedures.

Most of these errors in the care of chest disease seem almost too simple to document. When one sees these errors made repeatedly, it becomes apparent that we should do all we can to prevent the human factor from operating to the disadvantage of the patient. Only by going over the way in which mistakes are made can we hope to prevent them.

384 Peachtree St., N.E.

Ophthalmology Fellowships to Be Given

EIGHTEEN FELLOWSHIPS for residents in ophthalmology will be established over the next three years by the Guild of Prescription Opticians of America, Galen B. Kilburn, Atlanta, president, says.

Each fellowship will provide a total stipend of \$1,800, payable in monthly installments over the three-year period of residency. These fellowships are being provided on a regional basis, with the United States and Canada divided into six geographical

areas. One fellowship in each of the six areas will be initiated this year, a second one next year, and a third one the third year, when the total number of fellowships will reach eighteen. Thereafter as each three-year residency is completed a new fellowship will become available.

For information, write to the Guild of Prescription Opticians of America, Inc., 110 East 23rd Street, New York 10, N. Y.

Benign Prostatic Hypertrophy

RUDOLPH BELL, M.D., and ROY F. STINSON, JR., M.D., Thomasville, Georgia

BENIGN PROSTATIC HYPERTROPHY is a pathological overgrowth of portions of the prostate gland, usually the middle and lateral lobes. The pathological change is nothing new. In fact, the condition is as old as is man. Since the beginning of time man has sought theories to explain the cause and remedies to prevent prostatic hypertrophy. It has long been observed that eunuchs and postoperative castrates were not affected with prostatic enlargement. As the interrelationship between the prostate gland, testes, and the anterior pituitary gland becomes more clearly recognized, the theory of endocrine imbalance as the cause of prostatic hypertrophy becomes more popular. Until these conditions are more clearly understood, prostatic hypertrophy and its sequelae have to be treated as a major factor in the realm of medicine.

For the sake of simplicity, the simple benign hypertrophy is to be arbitrarily divided into early and late hypertrophy. The early hypertrophy is the case in which the symptoms are recognized and proper treatment instituted at an early date. The late hypertrophy is the case in which the condition has gone neglected over a period of time and complications and sequelae have become manifested. The early symptoms of benign prostatic hypertrophy are a diminution in the size of the urinary stream, loss of force, difficulty in starting the urinary act, nocturia, or getting up at night to pass urine, and a feeling of an inability to empty the bladder.

In all prostatic cases a complete history should be obtained and a complete physical examination made. Blood chemistries and renal functional tests are to be done. The size of the prostate gland, or the amount of obstruction that it is producing, cannot always be ascertained by digital rectal examination, but a digital rectal examination is a requisite in the examination of an adult male. Sometimes very large glands encroach and fill the urinary bladder instead of protruding and pressing against the rectal wall, which makes it inaccessible to digital rectal examination. One very valuable test to determine the amount of obstruction produced by the prostate gland is to have the patient void and immediately afterwards

insert a soft rubber catheter and determine the amount of urine left in the bladder, the so-called residual urine.

It would be best if all prostatic patients went into an acute urinary retention at an early date rather than suffer the sequelae and complications as a result of carrying a large amount of residual urine over a period of time. As the patient strains to attempt to pass urine or force urine over the enlarged prostate, a back pressure is produced on the kidneys. The kidney pelvis, or so-called reservoir, becomes dilated. As the pelvis dilates it encroaches on the normal kidney substance. As the parenchyma, or normal kidney substance, becomes encroached upon there is a suppression of urinary secretion. As the suppression develops, the arterial system attempts to force more blood through the kidneys so as to increase the urinary output. This creates a greater demand for work of the heart muscles. As the condition progresses the heart becomes enlarged and, too, a substance known as renin is manufactured in the beginning Goldblatt kidney. High blood pressure and hardening of the arteries ensue. There is a retention of nitrogenous substances in the blood. As this increases, stomach disorders may become manifested. The patient may ultimately become uremic. The symptoms of these sequelae and complications may be much more pronounced and overshadow the prostatic symptoms, or the primary source of the trouble.

The length of hospitalization for the prostatic patient depends entirely upon the condition on arriving at the hospital. If the case is of long standing, or the so-called late prostatic hypertrophy, it may be necessary to keep the individual on catheter drainage and supportive treatment for 10 days or two weeks before his condition reaches a maximum improvement, or becomes suitable for surgery. Prostatic surgery should not be regarded as an emergency procedure. Usually, in the early prostatic patient surgery can be employed within two or three days after admission to the hospital, and the necessary stay in the hospital may not be over a week or 10 days.

There are four surgical procedures for correction of prostatic hypertrophy, namely: (1) Transurethral prostatic resection. (2) Perineal prostatectomy. (3)

Presented at the 105th Annual Session of the Medical Association of Georgia, Augusta, Ga., May 1-4, 1955.

Retropubic prostatectomy. (4) Suprapubic prostatectomy. The first type, or the transurethral method of correcting the prostate gland, is done by passing an instrument through the normal passage and removing the obstructive portion of the gland without open operation. This type operation is most suitable for median lobe enlargements of the gland. It carries with it less morbidity and less shock than the open type of surgical procedure. It is the type operation most commonly employed in suitable cases. The second type, or the perineal prostatectomy, is done by making an incision between the scrotum and rectum and removing the gland in this manner. The perineal operation is most useful in suspected malignant cases and in prostatic stones. It is the type most suitable for radical prostatectomies. The third type operation, or the retropubic prostatectomy, is done by making an incision through the low midline of the abdomen, freeing the prostatic capsule laterally and opening it transversely. The prostate gland is enucleated without opening the bladder. Usually a V-wedge is removed from the vesical neck in this procedure. The morbidity in retropubic prostatectomies is perhaps lower than in any of the other types of open operations. The fourth type operation, or the suprapubic prostatectomy, is done by making an incision low over the midline of the abdomen and opening the bladder, through which the prostate gland is enucleated. This is the so-called old type method of removing the prostate gland. Formerly, the suprapubic operation was done in two stages, but now a two-stage operation is rarely employed as the prostatic

patient can be prepared by urethral catheter drainage and supportive treatment just as well as by suprapubic catheter drainage. Quite frequently now the bladder is closed tight following a suprapubic operation which, of course, reduces the morbidity considerably.

Summary

No one operation is suitable for all types of prostatic hypertrophy. The operation should be selected to suit the individual case. A prostate gland operation is not an emergency procedure. The individual should be left on catheter drainage and supportive treatment until his condition reaches maximum improvement. One should be qualified to do all types of prostatic surgery in order to render the best care to the prostatic patient. The prostatic patient can be rehabilitated. Usually, he is self supporting and a very useful citizen for many years after the prostate gland has been removed.

818 Gordon Ave.

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Who Supports Medical Students?

AS THOUSANDS OF BOYS AND GIRLS were graduated from high school last month, Dr. Elmer Hess, president of the American Medical Association, offered a word of encouragement to those who would like to attend medical school.

Quoting figures from the Association of American Medical Colleges, Dr. Hess said that the most important sources of students' income in 1955-56 were vacation earnings, personal earnings of the student during the year, earnings of the student's wife, gifts from parents and the G.I. Bill.

Dr. Hess said that while he did not want to encourage students to take on the added responsibility of a family, it is a fact that the largest average amount of income was wives' earnings. Eighteen per cent of the students reported that their wives' earnings, averaging \$2,500, were the largest source of income.

Last year the largest group of medical students (33 per cent) came from families in which the father was a laborer or in the lower levels of business. Only

10 per cent were children of physicians, while 25 per cent were children of executives or men in managerial positions and 16 per cent of persons in professions other than medicine. The fathers of 16 per cent were deceased, retired, unemployed or their occupations not indicated.

Ten per cent of the students reported that vacation earnings represented the largest source of income, while 40 per cent reported it to be gifts or loans, averaging \$1,000 a year, from their parents. Seventy-nine per cent had no more than three sources from which they obtained money and only 11 per cent said their parents were their sole source of income.

Dr. Hess pointed out that financial aid for students is available at many schools with 72 of the 81 approved medical schools in the country permitting freshmen to work and 78 allowing upperclassmen to hold jobs. Forty-three schools offer scholarships and 59 offer loans to freshmen. Twenty schools give cash prizes, 72 offer scholarships and 81, other loans.



Medical Education, Economics, And Realism

WITH THE COSTS OF MEDICAL education ever spiraling upward, the dilemma faced by most schools of medicine appears to be an endless one. The proposed solutions to this problem of economics have been many, but in general most have thus far achieved little more than stop-gap aid for an extremely complex problem. The urgency of the situation is acute. On the one hand lies the danger of mediocrity in medical education, and on the other, the specter of extensive practice of medicine by the faculties of our schools of medicine in a vain attempt to achieve economic stability for the school.

In most instances these all-out attempts for economic stability have resulted in fewer and fewer hours available for teachers to teach. If by so weakening its quality of teaching a school achieves solvency, what is its reward? It must inevitably progressively lower its standards of teaching to fit with the ever diminishing time allotted to teaching by a so-called full time faculty. Our great medical teaching institutions in this country have achieved their stature only through the strength of their individual teaching programs, not from their fame as centers of medical practice. Teaching must always remain primary and should never be relegated to a secondary position in any center of learning.

Have our medical institutions ever seriously considered increasing tuition fees to realistically meet their ever increasing deficits? On the average, most schools underwrite about 75 per cent of the total cost of educating a student. Tuition is designed to defray the remainder. Why would it not be feasible to increase tuition to 50 per cent of the total cost of student education? This would roughly double the cost to the student. To take care of the student's entire financial obligation to the school, a loan fund could be set up at very low interest rates which could be paid off within 10, 15, or 20 years following graduation. This would allow a competent student with no financial means to avail himself of a medical education. The increased revenue to the schools should take care of the deficits now being incurred by most institutions. All loyal alumni as well as big business would be glad to contribute to such a loan fund if it could be shown that such a plan was on a firm business basis and that it was not just another form of stop-gap aid.

Aldosterone

ALDOSTERONE, THE 18-ALDEHYDE derivative of corticosterone, was discovered independently by Luetscher and collaborators and by Simpson and Tait and their co-workers in 1953. Luetscher first found a powerful desoxycorticosterone-like substance in the urine of patients with nephrotic, cardiac, and hepatic edema. He was able to separate this through the use of column chromatography in sufficient amounts to identify it chemically and to do bioassays. In experimental animals it has a salt retaining potency and a potassium-excretion promoting effect nearly 100 times that of desoxycorticosterone acetate. The urinary excretion of this substance is increased in animals by restricting salt intake and is decreased by increasing salt intake. Its secretion is suppressed to a lesser degree by a fall in blood potassium and is increased by a rise in blood potassium.

The role of aldosterone in edema formation is not entirely clear at the present time. That it is of considerable importance is suggested by Luetscher's work, but there are still unanswered questions. For instance, the trigger mechanisms for its secretion in diseases which produce edema are unknown. Also tumors of the adrenal cortex which secrete large quantities of aldosterone and cause marked sodium retention and potassium loss by the kidney are not accompanied by edema formation. Adrenal tumors may secrete several different hormones and the balance between these may determine whether or not edema occurs. It is possible, too, that the anti-diuretic hormone has to be stimulated simultaneously to produce edema. It is surprising, though, that the rise in blood sodium produced by aldosterone does not in itself cause stimulation of the antidiuretic hormone. Despite all these problems one cannot help but feel that a great step forward has been made in the study of the pathogenesis of edema formation. The discovery of amphenone, an adrenal cortical suppressing agent, raises the hope that the control of edema may be accomplished. While amphenone is toxic and unfit for clinical use at present, other less toxic substances will undoubtedly be forthcoming.

Abolition of edema without correction of the underlying disease may be harmful in some instances and it may be necessary to exercise control rather than strive for complete abolition.

Hormone Therapy in Rheumatic Fever

J. GORDON BARROW, M.D., Atlanta, Georgia

WHEN HORMONES were first used in the treatment of active rheumatic fever it was hoped that they would, by their anti-inflammatory action, shorten the course of the illness and lessen the incidence of heart disease by preventing valvular swelling and scarring. This was a reasonable rationale, and it is disappointing to find, in the first good study available, that hormone therapy does neither, and is in the majority of instances no better than aspirin.

The study referred to is the United Kingdom and the United States Joint Report on Rheumatic Fever, a report relating to children under 16 years of age and comparing the effect of ACTH, cortisone and aspirin on the course of active rheumatic fever and the incidence of rheumatic heart disease through one subsequent year. It is a well planned and detailed investigation, still continuing, in which there is random allocation of the drugs and rigid criteria for diagnosis, treatment, and reporting of results. There are few grounds for criticism, yet the question will be raised as to whether the six weeks period of treatment is long enough.

A quotation from the last paragraph of the summary will give a concise idea of the findings: "There was no evidence that any of the three agents resulted in uniform termination of the disease, and on all treatments some patients developed fresh manifestations during treatment. Treatment with either of the hormones resulted in more prompt control of certain acute manifestations, but this more rapid disappearance was balanced by a greater tendency for the acute manifestations to reappear for a limited period upon cessation of treatment. Treatment with the hormones also led to more rapid disappearance of nodules and soft apical systolic murmurs. At the end of one year there was no significant difference between the three treatment groups in the status of the heart. During

the period of treatment, observation, and one year of follow up there were only six deaths."

In view of these findings it would be well to evaluate current practice in treating active rheumatic fever, both acute and convalescent.

There is at present a tendency to use hormones in even the mildest cases. It should be emphasized that bed rest is the mainstay of treatment, not drugs, and that bed rest should be absolute throughout the entire period of activity, whether drugs are being administered or not. The use of hormones during the low-grade activity of convalescence interferes with clinical observation as to cessation of activity, and hormones should never be used if ambulation is permitted.

The concept of rheumatic activity deserves comment. As far as heart valve damage is concerned, there may be little difference between acute and subacute rheumatic fever, and the long periods of low-grade activity, more innocent clinically, may be almost as treacherous in the production of valvular disease. In all instances it is important to diagnose rheumatic subjects as active or inactive, and all active rheumatic fever should be treated by complete bed rest. When all signs of activity have subsided, gradual ambulation is permitted. Occasionally signs of activity reappear on gradual ambulation, and in this instance further bed rest is indicated before ambulation is permitted again.

It is now felt that hormones should be reserved for treatment where there is danger of death from carditis. Some authors regard hormone treatment in this instance as lifesaving, but at present this may be more a clinical impression than established fact.

For nearly all cases of active rheumatic fever, then, the expensive hormones are not better than the inexpensive aspirin, and bed rest remains of prime importance.

Prepared at the request of the Committee on Professional Education
of the Georgia Heart Association.



physician's bookshelf

Books Received

Trussell, Ray E., M.D., *Hunterdon Medical Center; The Story of One Approach to Rural Medical Care*, The Commonwealth Fund, Harvard University Press, Cambridge, Mass., 1956, 236 pp., \$3.75.

Rosenfeld, Leonard S., M.D., M.P.H., and Henry B. Makeover, M.D., *The Rochester Regional Hospital Council*, The Commonwealth Fund, Harvard University Press, Cambridge, Mass., 1956, 204 pp., \$3.50.

Winslow, Walker, *The Menninger Story*, Doubleday and Company, Inc., Garden City, N. Y., 1956, 350 pp., \$5.00.

Ellis, Rhoda, Ph.D., *Dictionary of Dietetics*, Philosophical Library, New York, 1956, 152 pp., \$6.00.

Frederick, Portia M., and Carol Towner, *The Office Assistant in Medical or Dental Practice*, W. B. Saunders Company, Philadelphia, 1956, 55 figs., 351 pp., \$4.75.

Fuhrmann, C. Frederic, B.A., M.D., C.M., *The Management of Menstrual Disorders*, W. B. Saunders Company, 1956, 121 figs., 350 pp., \$8.50.

Hingson, Robert A., M.D., and Louis M. Hellman, M.D., *Anesthesia for Obstetrics*, J. B. Lippincott Company, Philadelphia, 1956, 344 pp., \$12.50.

Wolstenholme, G. E. W., and Cecelia M. O'Connor, *Histamine* (Ciba Foundation Symposium), Little, Brown and Company, Boston, 1956, 472 pp., \$9.00.

Reviews

De Lee, Sol T., M.D., **SAFEGUARDING MOTHERHOOD**, J. B. Lippincott Company, Philadelphia, 1953, 140 pp.

This book of 140 pages was written for the obstetrical patient who desires to learn as much as possible about pregnancy, labor, and the puerperium. The author, a nephew of Dr. Joseph B. DeLee, discusses in considerable detail the anatomy and physiology of the female reproductive tract, physiology of pregnancy, fetal development and growth, mechanism of labor, analgesia and anesthesia, and the emergencies and serious complications of pregnancy, labor, and the puerperium. The book is well illustrated and is written in such language as to be easily understood by a patient of average intelligence. A complete glossary is included to make medical terms more understandable to the reader.

The author's views concerning the instruction of patients on some of the minor antepartum and postpartum problems are a little too dogmatic and inflexible to make this a good book for general use by obstetrical patients. Many patients will find the book at variance with what their own physicians have told them on these minor points and may be confused as to what to believe. Had the author left a little leeway for differences of opinion on these relatively unimportant problems the book would have to be considered as one of the best of its type yet written.

William C. Helms, M.D.

Harvey, A. McGee, M.D., and James Bordley, III, M.D. **DIFFERENTIAL DIAGNOSIS, THE INTERPRETATION OF CLINICAL EVIDENCE**, W. B. Saunders Company, Philadelphia, 1955, 665 pp., \$11.00.

This excellent treatise on the principles of differential diagnosis is the outgrowth of the extensive experience of

both authors in the field of diagnosis and teaching. Stress is laid on basic principles of approach to clinical problems with proper utilization of the many medical disciplines at the disposal of the present-day clinician. Ninety illustrative cases have been judiciously utilized in the demonstration of basic principles of accurate differential diagnosis. Duplication has been kept to a minimum in these cases. No attempt has been made to deal systematically with the whole field of medical diagnosis but rather to present the subject as a systematized discipline. In the presentation of actual cases, the conditions under which a physician must work are simulated, and the orderly sequence of beginning with a complex situation and working toward a simple solution is demonstrated.

The section on methods and principles is followed by chapters which have no sequential significance. In these chapters the reader is given an opportunity to follow the process of differential diagnosis as it was actually employed by others in clinical pathological conferences. In this connection much credit is given to the methods and teachings of the late Doctors Louis Hamman and Warfield Longcope, both of whose influence is strongly felt in this book. The chapter headings represent important signs or symptoms which may be caused by several different diseases. Each chapter begins with a brief discussion of the diagnostic implications of the subject followed by the presentation of a series of illustrative cases. The discussion of differential diagnosis which follows the case histories is exactly the same as the one offered at the C.P.C., before the correct diagnosis was revealed by the pathologist. In this way, the reader may develop a sound approach to differential diagnosis by observing both the successes and the failures of those experienced in the field. The bulk of the case material is taken from the clinical pathological conferences at the Johns Hopkins Hospital.

This book should prove a most welcome complement to those time-honored textbooks that give a list of findings which help one to distinguish other diseases from the disease in question, or to those condensed treatises which enumerate in orderly fashion the various diseases which give rise to a particular sign or symptom. It is a book long overdue and one which should receive wide acceptance from students and practitioners alike.

Laughlin, Henry P., M.D., **THE NEUROSES IN CLINICAL PRACTICE**, W. B. Saunders Company, Philadelphia, 1956, 802 pp., \$12.50.

In clear and excellent style, the author has written a most informative treatise on the neuroses. Especially noteworthy is his classification of anxiety and its differentiation from fear. The efforts put forth in avoiding anxiety, shadowed by the individual's basic behavior patterns, produce the various symptom formations and the sum total of the presenting personality (ego). Each neurosis has been expertly explained with reference to its endogain (the precipitating cause) and the epigain (the secondary gain).

The chapter devoted to definitions of various intrapsychic mental mechanisms of defense, such as, introjection, projection, repression and suppression and the like, are well presented and much needed to clarify the vast terminology.

The author stresses the importance of insomnia, especially in the early mornings, of the depressed patient who will

The books listed above have been received and are hereby acknowledged. This listing should be a sufficient

return for the courtesy of the sender. Books of unusual interest will be reviewed as space permits. THE EDITOR

more often commit suicide after his recovery period has set in.

Emotional fatigue states, not often included in psychiatric books, are discussed at some length. The perverse technique of "brain washing" with its ego splitting and destruction is very dramatic and has been made doubly interesting by citing the cases of Micheal Shipkov and Cardinal Mindszenty.

This book is a valuable addition to the psychiatrist's library and should be read by physicians in the other specialties; so that they might become more aware of emotional illnesses. From this book, the physician can learn to more carefully screen his patients and prepare them for acceptance of psychiatric guidance when it is needed.

William R. Crowe, M.D.

Reed, Sheldon C., **COUNSELING IN MEDICAL GENETICS**, W. B. Saunders Company, Philadelphia, 1955, 268 pp., \$4.00.

This book is intended to serve as a guide for physicians whose advice is sought regarding eugenics, inbreeding, disputed parentage, adoptions, and similar human applications of the science of genetics. It is more concise (and less authoritative) than Stern's *Principles of Human Genetics*, and it will not serve as a useful vehicle for imparting much understanding of the fundamental principles of heredity. However, it does contain the necessary information (insofar as it is known) to enable one to give prospective spouses and parents who have undesirable traits in their ancestry, or who have already produced defective offspring, the probability of the recurrence of the traits.

Among the topics discussed those most useful to the genetics counselor are: mongolism, Rh factor, skin color, epilepsy, diabetes, schizophrenia, and fibrocystic disease of the pancreas. Less common inheritable disorders are included in an appendix.

The volume is well indexed, and a useful bibliography is given, but the merit of the book is marred by poor proof-reading, carelessly placed decimal points in two instances, puerile attempts at humor, and, in some cases, poor selections of illustrative examples.

Eugene Brown, M.D.

Roback, A. A. (Editor), **PRESENT-DAY PSYCHOLOGY**, Philosophical Library, New York, 1955, 995 pp., \$12.00.

Present-Day Psychology, edited by A. A. Roback is a very interesting survey of departments, branches, methods and phases of psychology.

This is a symposium with 40 contributors, most of them psychologists; however, in the section on Dynamic and Clinical Psychology, eight of the authors are physicians with or without academic psychological training.

This is probably the most comprehensive collective survey in psychology to date. In reviewing the headings of the 40 chapters one is amazed at the wide range of present day psychology and the vigorous application of this relatively young science to so many different areas.

The chapter on Integrational Psychology is particularly significant. It points up the trend in American psychology toward more and more specialization and toward extreme emphasis upon research which is objective, quantifiable and experimental; the kind of research which demands that the young psychologist pick a specific and well delineated problem suitable for a quantitative, experimental attack, and to keep a steady stream of research articles on this specialty pouring into the ever increasing array of psychological journals. Unfortunately, however, this trend does not encourage integrating and unifying the tremendous variety of research on disparate topics into a core of psychological knowledge.

Although this is a relatively representative presentation of psychology as it is today, there are certain exclusions

which are important. For instance, the field of learning, in which the greatest concentration of theory building and research in psychology and the most vigorous scientific methodology is demanded, seems almost completely neglected. This is one of the integrating and unifying threads that runs through all the departments and branches of psychology.

This is an excellent book for anyone who is interested in just what psychology is. It is also a good book to give one a proper perspective on the clinical applications of psychological knowledge as merely a part, and not the whole of psychology.

William C. Rhodes, Ph.D.

Rushmer, Robert F., M.D., **CARDIAC DIAGNOSIS**, W. B. Saunders Company, Philadelphia, 1955, 447 pp., \$11.50.

This book can be read with pleasure and profit by student and specialist alike, but it will offer more to the former. The title is misleading as to content, unless one pays attention to the subtitle noted on the title page (and not on the spine of the book)—"A Physiologic Approach." Three-fifths of the book is devoted to the physiology of the heart and circulation, and is rewarding; the remaining two-fifths is devoted to the diagnosis of cardiac diseases, and is disappointing.

The organization of the book, as stated in the author's preface, is simple, consisting of four chapters on cardiovascular anatomy and physiology (Part I); three chapters on the regulation of the heart and vessels (Part II); two chapters on the cardiac reserve and the etiology of congestive failure (Part III); five chapters on diagnostic techniques (Part IV); and five chapters on the application of the foregoing to the diagnosis of heart disease (Part V).

Illustrations and diagrams constitute one of the most attractive features of the book. One can learn much by turning pages, studying diagrams and reading legends. The text is, however, not so colorful, and the writing is frequently dull and unemphatic.

Some subjects are inadequately treated. One could desire a better presentation of the method and application of cardiac catheterization; those unfamiliar with the technique are not likely to learn anything about it here. The coverage of other subjects is excellent. One is not likely to find a better exposition on the arterial pressure and its measurement. The chapter on heart sounds and murmurs, and the chapters on electrocardiography are very good.

The usefulness of this worthwhile book on the physiologic principle of cardiac diagnosis will depend on the knowledge and interest of the reader, but I can imagine few who will not find it profitable.

Manuel N. Cooper, M.D.

Spector, William S. (Editor), **HANDBOOK OF TOXICOLOGY**, Volume 1, W. B. Saunders Company, Philadelphia, 1956, 963 pp., 173 illustrations, \$13.00.

The tables of data contained in this publication, in our opinion, are very complete. We feel the greatest value will be the availability of the references to the literature, especially for many of the rather uncommon toxic substances.

It is unfortunate the authors were not able to give data on human toxic levels. However, the comparative figures on acute toxicity of various substances for laboratory animals are useful in certain instances in indicating probable lethal dose for man.

This volume certainly places at the finger tips of the toxicologist a great number of rather rare toxic compounds. This fact together with the references given certainly makes available an easy search of the literature for further information which should be helpful and valuable.

Herman D. Jones, Ph.D.



abstracts by georgia authors

Durham, William F., Ph.D., Thomas B. Gaines, B.S., and Wayland Hayes, Jr., M.D., Ph.D., C.D.C., Public Health Service, U. S. Dept. of Health, Education, and Welfare, Savannah, Ga. "Paralytic and Related Effects of Certain Organic Phosphorous Compounds," *Arch. Indust. Health* 13:326-330 (April) 1956.

The structural similarity between the organic phosphorous compounds, presently in use as insecticides, and triorthocresyl phosphate, the etiological agent of "jake-leg paralysis," has evoked an interest in the possible neurotoxic effect of the organo-phosphorous compounds now on the market or proposed for use as pesticides. Using paralytic effect in the chicken as the best available index of a possible paralytic effect in man, a group of organic phosphorous insecticides has been screened for this property. The compounds tested include chlorthion, DDVP, demeton, diazinon, EPN, malathion, and OMPA. No delayed paralytic effects were seen with any of the compounds tested. The chickens dosed with malathion and EPN developed leg weakness immediately after dosing. This weakness was reversible after malathion, but essentially irreversible after EPN.

Rumble, Lester, Jr., M.D., St. Joseph's Infirmary, Atlanta, Ga. "The Man Behind the Bag," *Sou. Med. J.* 49:368-376 (April) 1956.

This paper was given before the Anesthesiology Section of the Southern Medical Association as the chairman's address. It consists of an explanation of the philosophy underlying the technique of utilizing controlled ventilation throughout any surgical procedure, regardless of the type of procedure being carried out.

To substantiate some of the views expressed regarding carbon dioxide accumulation and oxygen want, there is presented in this paper a summary of work done on 35 patients in whom oxygen content and carbon dioxide content were measured periodically throughout the course of anesthesia.

The paper is divided into three sections. The first is entitled "A Common Denominator" in which it is pointed out that hypoxia and carbon dioxide accumulation are more the rule during anesthesia than the exception. The second section entitled "A False Philosophy" attempts to point out the fallacy in assuming that there is such a thing as a minor anesthetic. The third section, "A Possible Solution" describes briefly a technique of anesthesia primarily developed by the author, and points out certain distinct and decided advantages of this technique.

The article does not suggest that this is the final answer to the problem, but does point out certain discrepancies in present day methods of producing unconsciousness.

Galambos, John T., M.D., Barbara W. Massey, Melvin I. Klayman, M.D., and Joseph B. Kirsner, M.D., Emory University, Ga. "Exfoliative Cytology in Chronic Ulcerative Colitis," *Cancer* 9:152-159 (Jan.-Feb.) 1956.

Cytologic changes in the colonic epithelium of patients with active chronic ulcerative colitis are difficult to interpret and may falsely arouse suspicion of cancer.

Enlarged bland colonic columnar cells are recovered by the irrigation-suction collection method in almost all patients with active ulcerative colitis. The cells are similar in appearance to the large bland gastric cells of pernicious anemia. Enlarged active columnar cells, closely simulating malignant cells, are seen on some smears obtained by the irrigation-suction or by the colonic-washing method. The large bland and active cells usually disappear after complete healing of the colitis.

Finding of malignant-appearing cells in smears obtained by the irrigation-suction method does not necessarily indicate early carcinoma, since such results sometimes occur when no demonstrable cancer exists. However, observation of undifferentiated malignant cells in smears obtained by the colonic-washing method is reliable evidence of cancer.

Leigh, Ted F., M.D., Edgar F. Fincher, M.D., and Maxwell F. Hall, Jr., M.D., Emory Hospital, Emory University, Ga. "Evaluation of Routine Skull Films in Intracranial Meningiomas," *Radiology* 66:509-517 (April) 1956.

The routine skull series in a large group of proven intracranial meningiomas are analyzed to determine how frequently the diagnosis and localization of these tumors can be made or strongly suspected by such positive findings as localized bone destruction or production, abnormal vascular grooving, sella turcica deformities, pineal shifts, intracranial calcifications, and others. With such findings, the radiologist can often make the diagnosis of meningioma, either definitely or with reasonable certainty. In this respect he can be of immense help to the referring physician and surgeon in these radiological consultations.

Waller, Robert D., and S. M. Roberts, Veterans Administration Hospital, Augusta, Ga. "Cholecystographic Visualization of the Rokitansky-Aschoff Sinuses" *South. M. J.* 49:221-225 (March) 1956.

The authors reviewed the literature with reference to roentgenographic demonstration of Rokitansky-Aschoff Sinuses. The term is applied to the out-pouching or herniation of the mucosa into and through the muscularis of the gallbladder, some of which communicate with the lumen by epithelial lined ducts, others having large openings, and some with no communication. These changes are often seen by the pathologist and are associated with chronic cholecystitis. Sixteen cases were found and reviewed, and one additional case reported.

Findings were rather consistent. Radiographic demonstration is somewhat rare due to the inability of most diseased gallbladders to concentrate the contrast media. When visualization does occur, the findings are as follows in order of their most common occurrences:

(1) Concentric distribution of the contrast media seen approximately one mm. from the contrasted gallbladder lumen. (2) Abnormally shaped gallbladder shadow usually consisting of a "purse-string" narrowing near the neck of the gallbladder. (3) Poor or delayed emptying. (4) Lithiasis. (5) Mulberry appearance en face, a new diagnostic roentgen sign which was demonstrated in the case reported.

Of the 17 cases reported, 13 were proven pathologically as chronic cholecystitis with Rokitansky-Aschoff sinuses. The sinuses vary in size and number and measure up to five mms. in diameter. One table, two illustrations.)

Hurst, J. Willis, Emory University Hospital, Emory University, Ga. "The Venous Hum in the Neck" *GP* 13:96, (February) 1956.

Most normal children have a continuous murmur in the neck called a venous hum. This murmur varies with breathing and breath holding. It becomes louder or changes pitch when the head is turned to the side. It changes pitch or disappears when the appropriate neck veins are compressed and usually disappears when the patient lies down. This type of murmur may also occur in patients in whom the circulation is rapid because of pregnancy, anemia, thyrotoxicosis, or beriberi.

An abnormal continuous murmur can be produced by: (a) a patent ductus arteriosus, (b) an aortic septal defect, (c) the collateral vessels of truncus arteriosus, (d) a congenital pulmonary arteriovenous fistula, (e) a traumatic arteriovenous fistula, (f) the rupture of the sinus of Valsalva, and (g) the anomalous drainage of pulmonary veins. The most common of these is a patent ductus arteriosus. The typical murmur of patent ductus arteriosus progressively louder during systole, envelopes a loud second heart sound, and continues on in diastole with decreasing intensity. The murmur is not altered by the compression of the neck veins or by turning the head but may occasionally vary slightly with respiration. The murmur persists when the patient lies down.

R. C. Williams, M.D., Georgia Dept. of Public Health, Atlanta, Ga. "The Utilization of Pharmacists in the Smaller Hospitals," *Bull. American Society of Hospital Pharmacists.* (March-April), 1956.

The administration and development of the Hospital Facilities Construction Program in Georgia (Hill-Burton) during the past five years provides the background, experience, and facts upon which this paper is based. The figures although from the State of Georgia apply generally to the other Southeastern states. There are in Georgia, about 250 hospitals. Eighty per cent of these hospitals have a capacity of 50 beds or less.

Various plans are used by smaller hospitals to provide proper safe-guards to the professional supervision by trained pharmacists in handling the drugs in the smaller hospitals. In some smaller communities the hospital uses individual pharmacists on a rotating monthly basis. In other areas a pharmacist is selected for a longer period to serve as consultant. At the present time a 50 bed hospital in Georgia purchases approximately \$15,000.00 worth of drugs and medical supplies each year. The average 50 bed hospital usually maintains a drug and pharmaceutical inventory that varies in value from \$2,500.00 to \$3,500.00. Careful purchasing of such supplies for hospitals under the supervision of a pharmacist will insure significant savings in securing such supplies.

Hospitals throughout the State recognize the value of pharmacists in the purchasing of drugs, in keeping the medical staff informed of new drugs, and adhering to the dependability of therapeutic agents. Generally speaking the responsibilities of pharmacists serving a hospital on a part-time basis are:

1. The purchasing, storing, labeling, and dispensing of all drugs.
2. A periodic inspection of drug stock in the store room and in all nursing service areas of the hospital.
3. To develop and improve a closer relationship with all professional groups of the hospital in order to provide and improve needed pharmaceutical services.

Sadun, Elvio H., and Dorothy M. Melvin, C.D.C., Public Health Service, U. S. Dept. of Health, Education, and Welfare, Atlanta, Ga. "The Probability of Detecting Infections with *Enterobius Vermicularis* by Successive Examinations" *J. Pediat.* 48:438-441 (April) 1956.

A total of 1,842 cellulose tape preparations were collected on six consecutive days from 307 patients in a mental institution. The findings indicate that a single examination is not reliable for the detection of infections with *Enterobius vermicularis*. A lower efficiency in demonstrating infections by single examinations was obtained among groups with a lower prevalence. The differences in demonstrability in groups with varying incidences and intensities of infection largely disappeared after the third daily examination and the results, consequently, were directly comparable. It is believed that a system of six consecutive examinations reveals a high and consistent proportion of the existing infections.

Findley, Thomas, and W. D. Davis, Jr., Medical College of Georgia, Augusta, Ga. "Compensatory Renal Hypertrophy and the Anterior Pituitary," *SOUTH. M. J.* 49:137-140 (Feb) 1956.

A kidney enlarges after removal of its mate not because it has to put out more urine but because of trophic influences from the anterior pituitary-adrenocortical axis. Damage to one kidney or removal of both induces proliferation of the eosinophils in the anterior pituitary, cells believed to produce growth hormone. Sustained hypertension could be due to failure of the kidney tubule to respond to these trophic influences.

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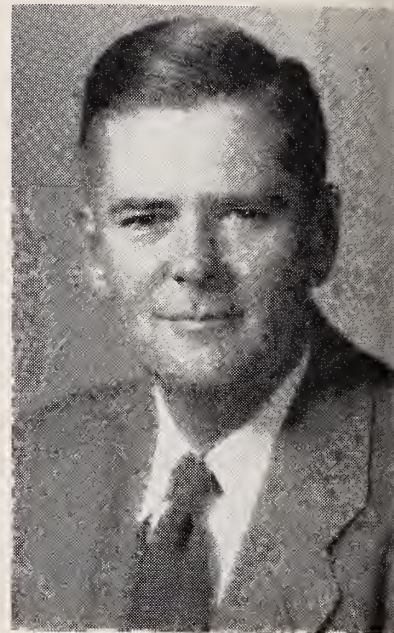
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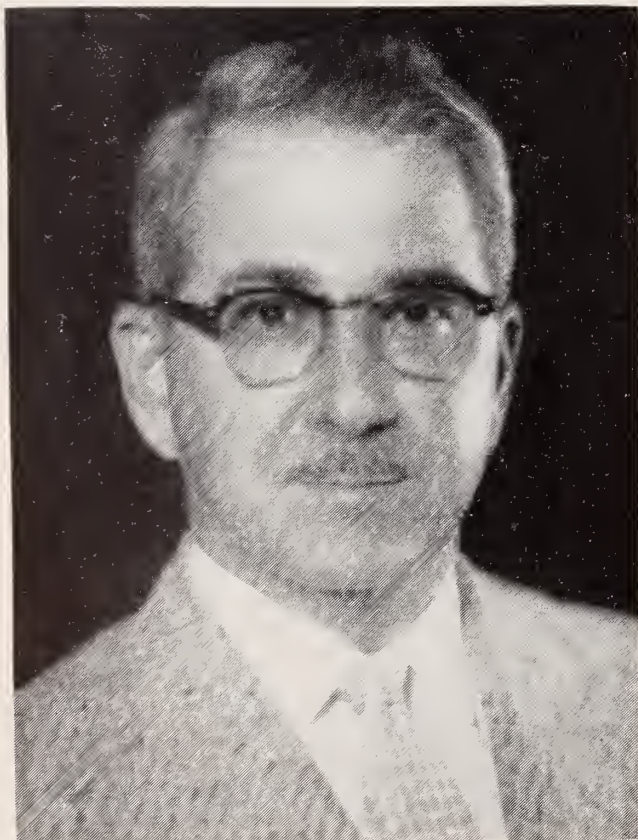
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A. S. Johnson, Sr., Elberton
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John H. Sherman, Augusta
C. M. Mulherin, Augusta
W. K. Philpot, Augusta
G. L. Kelly, Augusta

Columbus Advisory Subcommittee

Luther H. Wolff, Columbus, *Chairman*
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Peter C. Graffagnino, Columbus
Polk S. Land, Columbus
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Macon Advisory Subcommittee

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Harold C. Atkinson, Macon
Thomas L. Ross, Jr., Macon

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ACHROMYCIN

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The prevention and control of cellulitis, abscess formation, and generalized sepsis has become commonplace technique in surgery since ACHROMYCIN has been available. Leading investigators have documented such findings in the literature.

For example, Albertson and Trout¹ have reported successful results with tetracycline (ACHROMYCIN) in diverticulitis, gangrene of the gall bladder, tubo-ovarian abscess, and retropharyngeal abscess. Prigot and his associates² used tetracycline in successfully treating patients with subcutaneous abscesses, cellulitis, carbuncles, infected lacerations, and other conditions.

As a prophylactic and as a therapeutic, ACHROMYCIN has shown its great worth to surgeons, as well as to internists, obstetricians, and physicians in every branch of medicine. This modern antibiotic offers rapid diffusion and penetration, quick development of effective blood levels, prompt control over a wide range of organisms, minimal side effects. There are 21 dosage forms to suit every need, every patient, including

ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Broad-range antibiotic action to fight infection; important vitamins to help speed normal recovery. In *dry-filled, sealed* capsules for rapid and complete absorption, elimination of aftertaste.



¹Albertson, H.A. and Trout, H. H., Jr.: *Antibiotics Annual* 1954-55, Medical Encyclopedia, Inc., New York, N.Y., 1955, pp. 599-602.

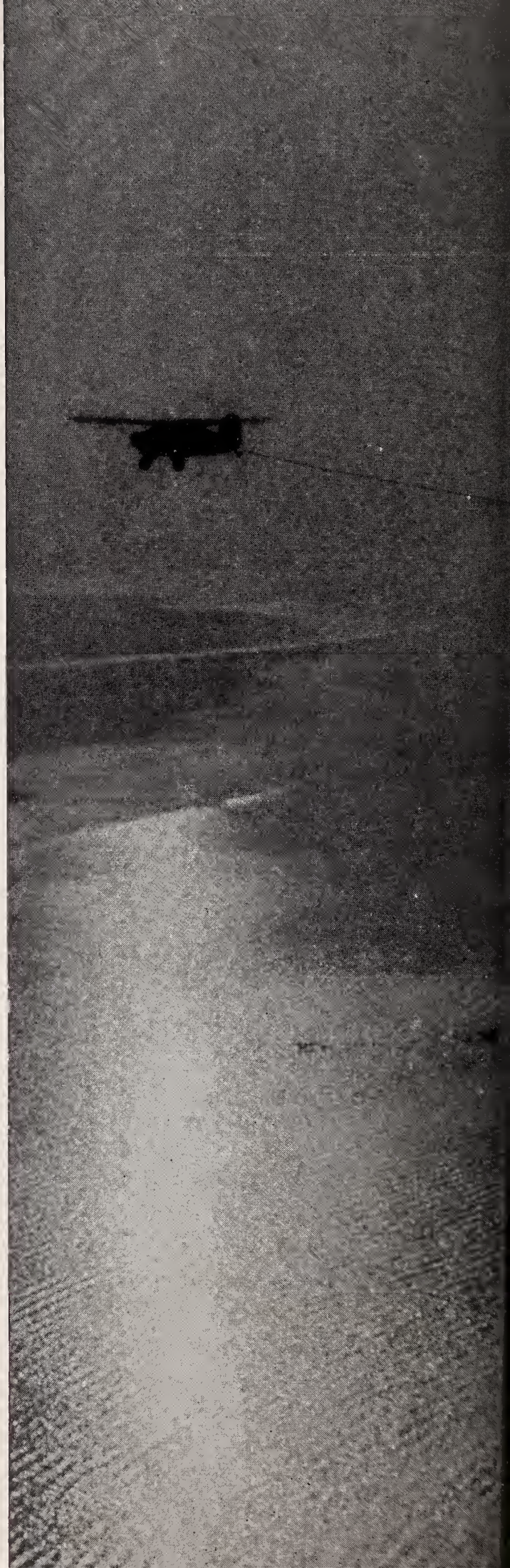
²Prigot, A.; Whitaker, J. C.; Shidlovsky, B. A., and Marmell, M.: *ibid*, pp. 603-607.



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ACHROMYCIN ACHROMYCIN



A SURVEY OF THE ANSWERS to the questionnaires, mentioned on this page in the May and June issues showed: first, that there is some lack of unanimity of opinion among doctors concerning their mutual problems and, second, that in the past individual doctors and medical organizations had been so occupied with their then present affairs that they had not concerned themselves very much with the future. This, of course, was natural, but today we must not allow ourselves to make the same mistake.

Many of our older doctors can recall the horse and buggy doctor who rode 10 to 15 miles to see patients and dispensed his medicines as he went along, those were the days when "galloping" consumption was considered hereditary because it occurred repeatedly in the same families. Go back to the first decade of this century and compare Len G. Broughton's Tabernacle Infirmary of a few beds located in two small apartment houses on Luckie Street, with neither laboratory nor x-ray facilities, to the Georgia Baptist Hospital, or any other similar modern hospital of today, with 500 or more beds. It is evident that the problems of maintenance, of personnel, of patients, and of finances are certainly different in today's hospitals. Add to these the cost of paying interns and residents and the problems of their training.

When I matriculated in the Atlanta College of Physicians and Surgeons, it had a part time dean who ran the college, a secretary, a stenographer, and a bookkeeper. There were full time salaried professors in chemistry, physiology, and anatomy; the same professor usually taught pathology and bacteriology. Any male who had the equivalent of a high school education, a letter from a preacher, and a matriculation fee could get in the college. If there were any money left over at the end of the year, it was divided among the heads of the clinical departments, all of whom worked without any salary. The students' tuition fees supported the institution, and the total cost to the student for four years of medical college was less than the cost of one year for the present day student. Compare the problems, financial and

others, of maintaining such a medical college and the modern one of today. The cost of medical education today is so great that students can't pay enough tuition to meet it. The balance must be obtained from other sources: the state, donations, private endowment, the Federal government, or from faculty activities. The standards of medical education must not be lowered, but let us select wisely the methods of financing it.

In addition to other duties, the responsibility for continued post-graduate medical education of proper standards is being placed on the medical colleges. This increases their financial burdens.

Let us consider then the changes in the standards of medical practice, in hospital management, and in medical education that have taken place in the last 40 years. Have we any right to believe that the next 40 years may not bring even greater changes in our problems of medical practice, hospital administration, and in medical education?

Differences of opinion among doctors and among medical organizations in regard to their problems exist for various reasons. All of us are apt to identify ourselves with our own ideas, customs, laws, etc., and to refuse to change or to cooperate with others. Consider the lack of uniformity in our divorce laws and in our traffic laws over the United States. Any 10 year old child knows that this lack of uniformity is silly, but what do we do about it? Likewise, among doctors, opinions are at times based not on the facts involved, but are shaded by personal desires, likes and dislikes, prejudices, ignorance, indifference, by economic factors, and even by the age of the doctor. In other words, we doctors are just plain human beings after all.

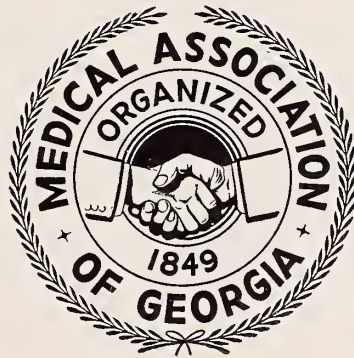
Fortunately, we have in our profession a hard core of mature, well developed, well educated men and women, who are unselfishly dedicating themselves to moulding the destiny of our profession, not only for the good of all its members, but for the good of all mankind.

Hal M. Wainson.

President

Constitution and By-Laws of the Medical Association of Georgia

As revised by the House of Delegates at the 106th Annual Session May 15, 1956
(Supersedes Any MAG Constitution and By-Laws Prior to May 15, 1956)



CONSTITUTION

ARTICLE I.

Nome of the Association

The name of this organization is The Medical Association of Georgia. It is an Association of its component county medical societies.

ARTICLE II.

Purposes of the Association

The purposes of the Association are to promote the science and art of medicine and the betterment of public health.

ARTICLE III.

Component Societies

Component societies are those county medical societies which hold charters from this Association or which may hereafter be organized and chartered by the House of Delegates of this Association which will form the Medical Association of Georgia.

ARTICLE IV.

Membership

SECTION 1. MEMBERS. *The members of the Association are the members of the component county medical societies. The Association is composed of Active, Service, Associate and Honorary members as provided for in the By-Laws. Other types of membership may be provided for in the By-Laws.*

SECTION 2. TENURE OF MEMBERSHIP. *A member shall retain his membership as long as he complies with the provisions of the Constitution and By-Laws of this Association and with the Principles of Medical Ethics of the American Medical Association.*

ARTICLE V.

House of Delegates

SECTION 1. COMPOSITION. *The House of Delegates is composed of Delegates elected by the component county medical societies as provided in the By-Laws. The general officers, the past presidents of the Association, the Treasurer, Editor of the Journal, Delegates to the AMA, the Executive Secretary and Chairmen of Standing Committees shall be ex-officio members of the House of Delegates without the right to vote.*

SECTION 2. DUTIES. *The House of Delegates is the legislative body of the Association, and it shall transact all business of the Association not otherwise specifically provided for in this Constitution and By-Laws.*

ARTICLE VI.

Council

SECTION 1. COMPOSITION. *The Council is composed of the President, the President-Elect, the Immediate Past President, two Vice-Presidents, the Secretary, the Speaker of the House of Delegates and ten Councilors as provided for in the By-Laws. The Treasurer, Editor of the Journal, Executive Secretary and Delegates to the AMA shall be ex-officio members of Council without the right to vote. Vice-Councilors shall be ex-officio members except in the absence of their respective Councilors as provided for in the By-Laws. The Vice-Speaker shall be an ex-officio member except in the absence of the Speaker as provided in the By-Laws.*

SECTION 2. DUTIES. *The Council is the Board of Trustees and the Board of Censors of the Association. It carries out the mandates and policies as determined by the House of Delegates. The Council has full authority and power of the House of Delegates between sessions of that body. The Council has charge of all property and financial affairs of the Association and performs such duties as are prescribed by law governing directors of corporations or as may be prescribed in the By-Laws.*

ARTICLE VII.

Meetings

SECTION 1. ANNUAL SESSION. *The Association shall hold an Annual Session at a time and place fixed by Council.*

SECTION 2. HOUSE OF DELEGATES. *The House of Delegates shall meet during the Annual Session and in interim sessions as may be determined by Council.*

SECTION 3. SPECIAL MEETINGS. *Special meetings of either the Association or the House of Delegates may be called by*

a two-thirds vote of Council, twenty delegates or upon written petition of one-fourth of the members of the Association.

ARTICLE VIII.

District Societies

In order to promote the best interests of the profession, the House of Delegates shall provide for the division of the State into Councilor Districts and for the organization of all component county societies in the districts into Councilor District Medical Societies.

ARTICLE IX.

Officers

SECTION 1. DESIGNATIONS. *The Officers of the Association shall be a President, President-Elect, two Vice-Presidents, the Immediate Past President, the Secretary, the Speaker of the House of Delegates, the Vice-Speaker of the House of Delegates, ten Councilors and ten Vice-Councilors as provided for in the By-Laws.*

SECTION 2. ELECTION AND ELIGIBILITY. *The officers of the Association shall be elected during the Annual Session as provided for in the By-Laws. No member shall serve as an officer who has not been a member of the Association for the preceding three years.*

SECTION 3. TERM OF OFFICE OF PRESIDENT-ELECT. *The President-Elect shall be elected annually and shall become President at the time of the next annual session. If the President-Elect shall be unable to serve, both a President and a President-Elect shall be elected at the appropriate annual session.*

SECTION 4. TERMS OF OTHER OFFICERS. *Other officers shall be elected for terms of one year each except the Secretary, Speaker of the House of Delegates, Vice-Speaker of the House of Delegates, and the Councilors and Vice-Councilors, who shall serve for three years. One-third of the Councilors and Vice-Councilors shall be elected annually. All officers shall serve until their successors are elected and installed.*

SECTION 5. SUCCESSOR TO THE PRESIDENT. *If the President dies, resigns, or is removed from office, the First Vice-President shall immediately become President and shall serve for the remainder of the unexpired term. If the First Vice-President is unable to serve, then the Second Vice-President shall fill the office.*

ARTICLE X.

Funds and Expenditures

Funds for the operation of the Association shall be raised by an equal per capita assessment on the members of each component society. The amount of the assessment shall be set by the House of Delegates upon recommendation of Council. Funds may also be raised by voluntary contributions, from the Association's publications, and in any other manner approved by Council. The Council shall submit an annual budget to the House of Delegates and shall manage the finances of the Association.

ARTICLE XI.

Official Publication

The official publication of the Association shall be the Journal of the Medical Association of Georgia, in which shall be published all official Association notices, abstracts of transactions of the House of Delegates and general meetings of the Association, the annual budget, complete financial report as directed by Council, and abstracts of meetings of Council.

ARTICLE XII.

Seal

The Association shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII.

Amendments

The House of Delegates may amend this Constitution at any session by a two-thirds vote of the Delegates present, provided that the proposed amendment shall have been introduced at the preceding session and provided that the proposed amendment shall have been published during the year in the Journal.

BY-LAWS

CHAPTER I.

Membership

SECTION 1. A physician holding the degree of Doctor of Medicine or Bachelor of Medicine from a medical college acceptable to the Council of the Association, licensed to practice medicine in the State of Georgia, who has been a citizen of the United States for at least two years and who has not been judged guilty of moral turpitude or other serious crime, may be eligible for membership after being certified by the secretary of a component society as being a member in good standing of said component county society.

SECTION 2. The name of a physician recorded on the official roster of a component county society, who has paid the annual dues and assessments of the component county society and of the Association, shall be prima facie evidence of membership in the Association.

SECTION 3. Membership in the Association shall be classified as Active, Service, Associate and Honorary. All eligible members should be encouraged to be active members.

SECTION 4. ACTIVE MEMBERS. Physicians who are members in a component county medical society and are eligible to vote and hold office in the society shall be Active members, unless otherwise classified by action of the component county society. These members shall have full privileges of Association membership including the right to hold office and vote, the privilege of Medical Defense and receipt of the Journal of the Medical Association of Georgia, and these members shall pay full dues to the Association annually. New members entering practice after July 1st may pay one-half the annual dues.

Active members may be excused from the payment of Association dues for one of the following reasons: (1) financial hardship or illness, (2) postgraduate training, defined as that period during which a member participates in an organized training course within a hospital, (3) being retired from active practice, or (4) on temporary service in the Reserve Armed Forces. A member excused from the payment of annual dues for service in the Armed Forces shall not be required to pay annual dues for the period beginning January 1 or July 1 following the date of the member's entrance into service. (5) A member in good standing who is over 70 years of age may also be excused from the payment of Association dues upon his application to the Association through his component county society; this exemption to begin the year following the member's 70th birthday. Active members excused from the payment of Association dues shall have the right to vote and hold office but shall not have the privilege of Medical Defense and shall not receive any publication of the Association except by personal subscription. Nothing in this section shall be construed to be retroactive to affect previously elected Life Members.

SECTION 5. SERVICE MEMBERS. Physicians eligible for Service Membership are all full-time commissioned Medical Officers of the Government, in the U. S. Army, Navy, Air Force, United States Public Health Service, Veterans Administration, and Indian Service, and those physicians who have retired from the Services by federal law and who do not engage in active practice. Such members shall not be required to pay the annual dues and shall not be entitled to vote and hold office and shall not have the privilege of Medical Defense, nor shall they receive any publication of the Association except by personal subscription.

SECTION 6. ASSOCIATE MEMBERS. Associate membership may be granted to physicians who are engaged in State and County medical services and full-time salaried members of approved medical faculties not engaged in the private practice of medicine provided similar action has been taken by the component county society. Associate membership, except as otherwise provided herein, also may be granted to any mem-

ber of a component county medical society. Associate members shall pay no dues and shall not be entitled to vote or hold office. They shall not be entitled to the privilege of Medical Defense or to receive any publication of the Association except by personal subscription.

SECTION 7. HONORARY MEMBERS. Physicians and persons holding the degree of Doctor of Philosophy who have risen to prominence in their professions may be elected to Honorary Membership by the House of Delegates. Nominations for Honorary Membership may be submitted to the House of Delegates by component county societies or Council. These members shall enjoy all the privileges of the Association but shall not vote or hold office nor shall they receive the privilege of Medical Defense or any publication of the Association except by personal subscription.

SECTION 8. TENURE. When the Secretary is officially informed that a member is not in good standing in his component society, he shall remove the name of that member from the membership roll.

SECTION 9. TRANSFER. Should a member remove his practice to another jurisdiction he shall apply for a continuance of his membership through the component society in the jurisdiction to which he has moved his practice.

CHAPTER II.

General Meetings

SECTION 1. The general meetings shall be open to all members and guests who have complied with the registration requirements. These meetings shall be presided over by the President or a Vice-President.

SECTION 2. The program for the general meetings shall be prepared by the Council of the Medical Association of Georgia and approved by Council at least sixty days before the annual session of the Association and published in an issue of the Journal preceding the Annual Session.

SECTION 3. All papers read before meetings shall be deposited with the Secretary or the presiding officer and shall become the property of the Association. Without an acceptable excuse, failure to comply with this and other rules as regards the Annual Session as set forth by the Council shall automatically prohibit a member from participating in scheduled scientific sessions for a period of not less than five years.

SECTION 4. The general meetings shall be open to all registered members. Distinguished lay persons and guest physicians may be invited as special guests of the Association by the President or by action of Council.

SECTION 5. LOCAL ARRANGEMENTS COMMITTEE. As soon as practicable following the close of each annual session the component society which will act as host at the next annual session shall elect Local Arrangements Committees which shall recommend suitable meeting places and shall have general charge of all local arrangements subject to the approval of Council.

CHAPTER III.

House of Delegates

SECTION 1. MEETINGS. The House of Delegates shall meet during the Annual Session at a time and place fixed by Council. The House of Delegates may also meet in interim sessions and at such other times as may be necessary for the transaction of the business of the Association.

SECTION 2. Each component county society shall elect one delegate and a corresponding alternate, each of whom has been a member in good standing for the prior three years, for each 25 members, or fraction thereof, whose dues have been paid by December 31st of the preceding year, provided that each component county society shall be entitled to at least one delegate. Delegates to the House of Delegates shall serve for a term of three years; one-third of the members

of the House of Delegates to be elected annually provided that the component county societies which are entitled to three or more delegates shall elect at their first election one-third of their delegation for a term of one year, one-third of their delegation for a term of two years, and one-third of their delegation for a term of three years and thereafter elect such delegates whose terms of office expire therewith. Those component county societies which are entitled to less than three delegates shall elect their delegate or delegates for staggered terms in rotation as may be determined by Council until one-third of the House of Delegates is being elected annually.

SECTION 3. Forty of the registered members of the House of Delegates shall constitute a quorum. All sessions of the House of Delegates shall be open to the members of the Association, except when in Executive Session.

SECTION 4. The House of Delegates shall be presided over by the Speaker or, in his absence, by the Vice-Speaker. In the absence of both, a delegate agreeable to it may preside. The Speaker and the Vice-Speaker shall be elected by the members of the House of Delegates and shall serve for a term of three years.

SECTION 5. The Secretary of the Association shall be the Secretary of the House of Delegates or, in his absence, a Delegate appointed by the Speaker of the House of Delegates shall serve as Secretary of the House of Delegates. The Executive Secretary may serve in this capacity.

SECTION 6. The following shall be the general Order of Business at all meetings of the House of Delegates: 1. Call to order by the Speaker; 2. Roll Call; 3. Election of Speaker and Vice-Speaker (every third year at second session of House of Delegates during Annual Session; their terms of office to begin with adjournment of the House of Delegates; provided a Speaker and Vice-Speaker be elected as the next order of business after the adoption of this by-law); 4. Reading and adoption of minutes; 5. Reports of officers; 6. Reports of committees. 7. Unfinished business. 8. New business.

At any meeting, the House by majority vote may change the Order of Business. New Business may be introduced at the final meeting of the House of Delegates only when such business is of an emergency nature or introduced by unanimous consent.

SECTION 7. For the purpose of expediting proceedings, the Speaker of the House of Delegates shall appoint from members of the House of Delegates the reference committees, the credentials committee, and other committees considered necessary. Any member of the Association may be appointed to serve on a committee created for a special purpose. Such members who are not members of the House of Delegates shall have the right to present their reports in person and to participate in debate, but shall not have the right to vote.

SECTION 8. All reports and resolutions shall be referred to the appropriate Reference Committees before action is taken by the House of Delegates.

CHAPTER IV. Council

SECTION 1. COMPOSITION. The Council is composed of the President, the President-Elect, the Immediate Past President, two Vice-Presidents, the Secretary, Speaker of the House of Delegates or the Vice-Speaker of the House of Delegates and one Councilor or Vice-Councilor from each Councilor District. Vice-Councilors shall be ex-officio members of Council, without the right to vote, except in the absence of their respective Councilors when they shall serve as Councilor. The Vice-Speaker shall be an ex-officio member of Council without the right to vote except in the absence of the Speaker when he shall serve in the Speaker's stead. The Treasurer, Editor of the Journal, Executive Secretary, and Delegates to the AMA shall be ex-officio members of Council without the right to vote.

SECTION 2. CHAIRMAN AND SECRETARY. A Chairman and a Vice-Chairman of Council shall be elected annually at the organizational meeting and shall serve for one year, or until their successors are elected. The Chairman or Vice-Chairman shall preside over meetings of Council and appoint all necessary committees of Council. The Secretary of the Association shall serve as Secretary of Council. The Council may designate the Executive Secretary or Assistant Executive Secretary to serve in this capacity.

SECTION 3. EXECUTIVE COMMITTEE. The Council shall organize an Executive Committee at the organizational meeting. The Executive Committee shall be composed of the President, the President-Elect, the Immediate Past President, the Secretary, the Chairman of Council, who shall serve as presiding officer, and the Chairman of the Council Committee on Finance. It shall meet monthly between the meetings of Council. The Committee shall make such recommendations to the Council and shall carry out such items of business as are referred to it by Council. The Executive Committee shall appoint all committee chairmen and committees of the Association and nominate members of all Boards required by the laws of the State of Georgia on recommendation of the District Societies where applicable; not otherwise provided for, subject to confirmation by Council, and shall serve as Publications Committee of the Journal. The Executive Committee shall recommend to Council the terms of employment and salaries of all personnel necessary to conduct the affairs of the Association. The Executive Committee shall be empowered to select an Executive Secretary who shall be responsible to the Executive Committee for his action and for the operation of the Headquarters Office, subject to the approval of Council. The Executive Committee shall act as a Board of Trustees directing the Executive Secretary in carrying out the mandates and policies of the Council and the House of Delegates.

SECTION 4. MEETINGS. The Council shall meet at the close of the annual session to organize and at intervals of not more than four months until the next annual session. Special meetings of Council may be held on the call of the President or upon the request of three members of Council. Regular meetings of Council will be held on call of the Chairman.

SECTION 5. GENERAL DUTIES. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the powers conferred on the House of Delegates by the Constitution and By-Laws. The Council shall provide such headquarters for the Association as may be required to conduct its affairs. The Council shall by appointment fill any vacancy in office not otherwise provided for, which may occur during the interval between Annual Sessions of the Association. The appointee shall serve until his successor has been elected and installed.

The Council shall authorize the payment of all necessary expenses incurred by the officers of the Association in the performance of their duties, except those incurred during the annual session. The Council, also, may authorize a special fund to be made available to the President of the Association, who may expend all or any part of it without restriction for the good of the Association.

SECTION 6. SPECIFIC DUTIES. The Council shall determine the employment and salaries of all personnel necessary to conduct the affairs of the Association on the recommendation of the Executive Committee of Council. The Council shall control and direct all Association publications.

SECTION 7. BOARD OF CENSORS. The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standing of members whether in relation to other members, to the component societies or to the Association referred to it by the Association's Professional Conduct Committee. Any question of an ethical nature may be brought before the Council by the

Committee on Professional Conduct or by any member of the Association or upon the request of the party concerned on which an appeal is taken from the decision of the Association's Professional Conduct Committee. It shall hear and decide all questions of discipline affecting the conduct of members of component societies, on which an appeal is taken from the decision of a component society or the Association's Professional Conduct Committee. Its decision in all cases, including questions regarding membership in the Association, shall be final subject to approval of the House of Delegates.

SECTION 8. COUNCILOR AND VICE-COUNCILOR DUTIES. Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of, and to aid in the betterment of, the component societies in his district. He shall make an annual report of his work, listing all eligible physicians in his district who are not members of a component society and of the condition of the profession of each county in his district at the annual session of the House of Delegates. The Vice-Councilor shall assist the Councilor in the performance of his duties. He becomes a voting member of the Council only in the absence of the Councilor from his district.

SECTION 9. COMMITTEE ON FINANCE. The Chairman of the Council shall appoint from among its members a committee of three members to be known as the Committee on Finance, which shall cause to be audited all accounts of the Association. The Council shall propose an annual budget for the fiscal year beginning January 1st after each annual session. This proposed budget shall be prepared by the Committee on Finance for the consideration of the Council at the last meeting in the last quarter of each year. This budget shall be presented to the House of Delegates for its approval. It shall also submit an annual report to the House of Delegates, which shall specify the character of all of its property and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

All expenditures made by the Local Arrangements Committee in connection with the annual session must be authorized in advance by the Committee on Finance. Council shall have control of all commercial exhibits at the Annual Sessions and any deficit created on account of the annual session shall be met by Council on recommendation of the Committee on Finance.

CHAPTER V.

Election of Officers

SECTION 1. ELECTION. The President-Elect, two Vice-Presidents, Secretary, Councilors and Vice-Councilors shall be elected by ballot by the members of the Association during the Annual Session. The President-Elect shall be elected annually and shall become President at the time of the next annual session. The Speaker of the House of Delegates and Vice-Speaker of the House of Delegates shall be elected by members of the House of Delegates and shall serve for a term of three years. Other officers shall be elected for terms of one year each except the Secretary, Councilors and Vice-Councilors who shall serve for three years. One-third of the Councilors and Vice-Councilors shall be elected annually.

SECTION 2. NOMINATIONS. Nominations for these officers except the Speaker and Vice-Speaker and the Councilors and Vice-Councilors shall be made orally from the floor as the last order of business at the first general session of the annual session and no nominating or seconding speech shall exceed two minutes. Nominations for Speaker and Vice-Speaker shall be made by members of the House of Delegates orally on the floor of the House of Delegates as

provided in the House of Delegates order of business. Nominations for Councilors and Vice-Councilors shall be made by each district society at its annual meeting and forwarded by its secretary to the Secretary of the Association not later than 15 days before the annual session. If no nomination is presented by a district society in this manner, nominations shall be made from the floor.

SECTION 3. METHOD. The President shall appoint a committee of not less than three Tellers immediately after the close of nominations, who shall have charge of the election. The Secretary shall have prepared in advance an official ballot and an official ballot box, which shall be kept in the custody of the Tellers Committee. One ballot only shall be given to each active voting member when he presents himself to cast his ballot. Such member and no other shall prepare his ballot and shall deposit it at that time in the locked ballot box.

The candidates for office receiving a majority of the votes shall be declared elected, but if no majority is received on the first ballot, the members present shall select by secret ballot the officer from the two candidates having the highest number of votes.

SECTION 4. TIME. Voting shall take place during the hours of the scientific program up to the beginning of the last meeting on the last day of the annual session. At that time the Committee of Tellers shall count the ballots and report their findings to the members.

SECTION 5. Delegates and Alternates to the American Medical Association shall be elected in the same manner and at the same time and in accordance with the Constitution and By-Laws of the American Medical Association.

CHAPTER VI.

Rights and Duties of Officers

SECTION 1. PRESIDENT. The President shall (A) preside at all general meetings of the Association; (B) address the opening General Session of the annual session; (C) assist the Councilors in improving the county and district societies as far as practicable; (D) serve as a member of Council and as a member of the Executive Committee; (E) serve as a member of all committees of the Association with the authority to call a meeting of any committee when necessity demands it or after failure of the chairman to do so. With the approval of Council, he may terminate any committee whose function has been fulfilled or replace any member of any committee who fails to show interest in performing the duties assigned to him; (F) he shall be an ex-officio member of the House of Delegates without the right to vote.

SECTION 2. PRESIDENT-ELECT. The President-Elect shall be a member of the Council and of its Executive Committee, and shall be a member ex-officio without the right to vote, of all Standing Committees. In order to acquaint himself with all the activities of the Association, it shall be his duty to attend all meetings of the Council and, when possible, the Standing Committees. He shall be an ex-officio member of the House of Delegates without the right to vote.

SECTION 3. THE VICE-PRESIDENTS. The Vice-Presidents shall be members of the Council. The Vice-Presidents shall assist the President in the discharge of his duties. Upon request or in the absence of the President, the Vice-Presidents will preside over the general meetings of the Association in rotation. In the event of the President's death, resignation, or inability to serve, the Vice-Presidents, in their order shall succeed him for the unexpired term. The Vice-Presidents shall be ex-officio members of the House of Delegates without the right to vote.

SECTION 4. SECRETARY. (A) The Secretary and the Executive Secretary shall attend the general meetings of the Association and the meetings of the House of Delegates. The Secretary shall keep the minutes of their respective proceedings.

At the request of the Secretary, the Executive Secretary may serve in this capacity. The Secretary, or upon his request, the Executive Secretary, shall be Secretary of the Council and its Executive Committee. The Secretary shall be an ex-officio member, without the right to vote, of the House of Delegates and all committees of the Association.

SECTION 4. (B) The Secretary and/or Executive Secretary, under the direction of the Executive Committee of Council, shall be custodian of all Association record books and papers, conduct the official correspondence of the Association, maintain membership records, issue membership cards and provide for the registration of members at annual sessions.

The Secretary shall collect the regular per capita assessment from the component societies and shall make all required reports to the American Medical Association.

SECTION 5. IMMEDIATE PAST PRESIDENT. The Immediate Past President shall serve for one year immediately following his term of office as President. He shall serve on the Council and its Executive Committee and shall be an ex-officio member of the House of Delegates without the right to vote.

SECTION 6. SPEAKER. The Speaker of the House of Delegates shall serve for three years after being duly elected by the members of the House of Delegates and he shall preside over all meetings of the House of Delegates. He shall also serve as a member of the Council concurrent with his term of office. It shall be his duty to preserve order and to follow the proper parliamentary procedures. It shall be the duty of the Speaker to have the representation of each component county society checked by the Committee on Credentials at the time of the Annual Session, and to fill such vacancies by appointment. Such temporary appointees shall be members of the component society having the vacancy. He shall appoint the House of Delegates Reference Committees and Credentials Committee.

SECTION 7. VICE-SPEAKER. The Vice-Speaker of the House of Delegates shall serve for three years after being duly elected by the members of the House of Delegates and he shall preside over the House of Delegates in the absence of the Speaker. The Vice-Speaker shall be an ex-officio member of the Council without the right to vote except in the absence of the Speaker when he shall serve in the Speaker's stead. In the event of the Speaker's death, resignation or inability to serve, the Vice-Speaker shall succeed him for the unexpired term.

CHAPTER VII.

Component County Societies

SECTION 1. COUNTY SOCIETIES. All county societies now in affiliation with the Medical Association of Georgia or those hereafter organized in this state which have adopted principles of organization in conformity with this Constitution and By-Laws may receive charters from the Association, provided that their constitution and by-laws shall have been submitted to the Council and received its approval in this regard. A component society shall consist of three or more active members.

SECTION 2. CHARTER. Council shall provide and issue charters to county medical societies organized to conform to this Constitution and By-Laws. Such charters shall be signed by the President and the Secretary. The House of Delegates shall have authority to revoke the charter of any component county society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws. Only one component county society shall be chartered in each county.

SECTION 3. NAMES OF SOCIETIES The name and title of each component county society shall read exactly as found in its charter. No change in such name shall be made without the approval of the Council of the Medical Association of Georgia.

SECTION 4. CUSTODY OF CHARTER. The charter of each component county society as issued by the Medical Association

of Georgia, shall be preserved and shall be in the custody of the Secretary of such society at all times.

SECTION 5. PURPOSES. Each component county society shall promote the science and art of medicine and the betterment of public health in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of its members. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every acceptable and eligible physician in the county or counties in its jurisdiction.

SECTION 6. DUTIES. Each component county society shall meet the following five minimum standards: Each society shall (1) meet a minimum of four times a year, elect officers and delegates annually at a meeting before January 1st and report these officers to the headquarters office before January 1st; (2) maintain an up-to-date constitution and by-laws in conformity with the Constitution and By-Laws of the Medical Association of Georgia and shall transmit a copy of its constitution and by-laws to the headquarters office for record; (3) maintain a Board of Censors and/or a Mediation Committee; (4) maintain minutes of each meeting in a permanent record book that will be available at all times; (5) maintain scheduled programs at its minimum four meetings annually.

SECTION 7. DELEGATES. Each component county society shall elect at its annual meeting prior to January 1st Delegates and Alternates to the House of Delegates in accordance with these By-Laws. The secretary of each component society shall send a list of such delegates to the Secretary of the Association before January 15th. In the absence of, or the disability or disqualification of a delegate, the vacancy may be filled by the President of the society from other members of the same component society, provided such vacancy is filled prior to the first session of the House of Delegates.

SECTION 8. COMBINED COUNTIES. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designated so as to distinguish them from district societies. These societies when chartered shall be entitled to all the rights and privileges provided for component societies. A physician residing in a county not having a component society shall be referred to an adjacent component county society by Council.

SECTION 9. ANNUAL MEETING. Each component county society shall designate a meeting held prior to January 1st as its annual meeting at which time officers and delegates for the next year shall be elected and their names forwarded before January 15 to the Secretary of the Association.

SECTION 10. DISTRICT SOCIETIES. District societies shall have one or more meetings during the year and shall nominate a Councilor and Vice-Councilor as provided in these By-Laws. These district societies shall be organized for the best interests of the medical profession in Georgia and shall not necessarily conform with the boundaries of congressional districts. District societies shall elect officers, adopt a constitution and by-laws in conformity with the Constitution and By-Laws of the Medical Association of Georgia and levy dues for the government of its own affairs.

CHAPTER VIII.

Funds and Expenditures

SECTION 1. TREASURER. The Treasurer shall be appointed annually by the Executive Committee of Council subject to the approval of Council. The Treasurer shall be a member in good standing for at least three years prior to his appointment and may be the same person as the Secretary. The Treasurer shall not be an officer of the Association but shall be an ex-officio member, without the right to vote, of Council and the House of Delegates. He shall be an ex-officio member, without the right to vote, of the Committee on

Finance. The Treasurer shall give bond in such sum as may be fixed by the Council the premium on such bond to be paid by the Association.

SECTION 2. TREASURER'S DUTIES. The Treasurer shall receive all funds of the Association together with bequests and donations. He shall pay money out of the treasury only on authorization of the Council; he shall furnish a balance sheet to the Council at its last meeting of the fiscal year. The fiscal year includes the period of time from January 1st to December 31st inclusive. A financial report shall be published in the Journal as soon as practicable after the end of each fiscal year. All checks for Association expenditures shall be signed by both the Treasurer and the Secretary, or by any two officers of the Association designated by Council.

SECTION 3. DUES AND ASSESSMENTS. (A) The annual dues and assessments shall be determined by the House of Delegates upon recommendation of the Council and shall be levied per capita on the active members of the Association. They shall be payable on or before January 1st of the year for which they are levied. The secretary of each component county society shall cause to be collected and shall forward to the office of the Association before January 1st the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the headquarters office of the Association on or before April 1 shall stand suspended until his name is properly reported and his dues for the current year properly remitted. At no time and under no circumstances shall a member make payment of dues or assessments directly to the headquarters office of the Association. Neither shall the headquarters office of the Association receive payments of dues or assessments from anyone except the secretary of the component county society or his representative.

An active member who fails to pay dues for one or more years shall be eligible for reinstatement upon payment of dues for the current year plus one year's dues in arrears subject to reapplication and approval by his county society.

SECTION 3. (B) The record of payment of dues and assessments on file in the office of the Association shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Association and of the House of Delegates.

SECTION 3. (C) For the purpose of medical defense a member shall be deemed in arrears from and during the period extending April 1st of the current year until his dues and assessments shall have been received at the office of the Association, having been remitted by the secretary of the component county society of which he is a member.

SECTION 3. (D) Any county society which fails to make the reports required before the annual session of the Association shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Association or of the House of Delegates.

CHAPTER IX.

Standing Committees

SECTION 1. The Standing Committees of the Association shall be as follows:

- A) Committee on Legislation
- B) Committee on Medical Education
- C) Committee on Medical Defense
- D) Committee on Professional Conduct
- E) Committee on History and Vital Statistics
- F) Committee on Public Health
- G) Committee on Maternal and Infant Welfare
- H) Committee on Rural Health
- I) Committee on Industrial Health
- J) Committee on Public Service
- K) Committee on Cancer

- L) Committee on Insurance and Economics
- M) Committee on Veterans Affairs
- N) Committee on Constitution and By-Laws
- O) Committee on Scientific Exhibit Awards
- P) Committee on Woman's Auxiliary
- Q) Committee on Hospital Relations
- R) Committee on Crawford W. Long Memorial
- S) Committee on Mental Health
- T) Committee on Geriatrics

SECTION 2. Unless otherwise provided in these By-Laws, each of these committees shall consist of three members, each of whom shall serve for three years. Unless otherwise provided in these By-Laws, Executive Committee of Council shall appoint standing committee members and standing committee chairmen as needed. One member of each standing committee shall be appointed each year by the Executive Committee of Council to serve for three years. The Executive Committee shall make all appointments at least thirty days prior to the annual session and all standing committees shall hold their organizational meeting at the time of the annual session. The members of each committee shall serve staggered terms of office so that only one term shall expire each year. The President, with the approval of Council, may replace any member of any committee who fails to show interest in performing the committee duties assigned him. All committee chairmen shall make an annual report in writing to the Association headquarters office sixty days in advance of the annual session for consideration by the House of Delegates.

SECTION 3. (A) COMMITTEE ON LEGISLATION. The Committee on Legislation shall be composed of a chairman who shall have charge of matters pertaining to State of Georgia Legislation; a vice-chairman, who shall have charge of matters pertaining to legislation of the Congress of the United States, and three other members. The chairmen of the following committees shall serve as ex-officio members without the right to vote: Medical Education, Public Health, Maternal and Infant Welfare, Rural Health, Industrial Health, Insurance and Economics, Veterans' Affairs, Hospital Relations and Mental Health. The President of the State Board of Medical Examiners and the Chairman of the State Board of Health shall also be ex-officio members of this committee without the right to vote.

The duties of the committee shall be to represent the Association in securing and enforcing State of Georgia and Federal Legislation as directed by Council, in the interests of public health and scientific medicine. The Committee shall meet at least sixty days prior to the convened sessions of either the Georgia General Assembly or the Congress of the United States. The committee shall appoint at least ten key men, one from each congressional district to represent the committee in their area on matters pertaining to legislation of the Congress of the United States. As many other keymen as are needed shall be requested to represent the committee on matters pertaining to State of Georgia legislation.

SECTION 3. (B) COMMITTEE ON MEDICAL EDUCATION. The Committee on Medical Education shall be composed of a chairman and two other members and the deans of the medical schools in the State of Georgia who shall serve in an ex-officio capacity without the right to vote. The committee shall consider and devise means of extending the educational work of the Association for the benefit of its members, working with the component societies whenever possible and serve for the Council on Medical Education of the American Medical Association in this State. The Committee shall act as an advisory body in matters concerning medical education as directed by Council. All problems relating to the postgraduate study of medicine shall be referred to this Committee.

SECTION 3. (C) COMMITTEE ON MEDICAL DEFENSE. The Committee on Medical Defense shall consist of five members

of whom the Chairman of the Committee on Finance and the Secretary shall be members. The other members, one of whom shall be appointed chairman, shall be appointed by the Executive Committee of Council for terms of five years each. The duties of this Committee shall be to investigate any claim of alleged malpractice made against any member upon the written request to the Committee by said member. The Committee shall, on the advice of Counsel, in cases being worthy of defense, furnish the services of the Association counsel for the purpose of consultation and advice relative to threatened or actual litigation provided the Association does not assume financial obligation in excess of \$100.00 for any one member in any calendar year. Any charges or fees in excess of \$100.00 for any one member in any calendar year shall be borne by the member so requesting the privilege of medical defense consultation and advice as stated herein.

SECTION 3. (D), COMMITTEE ON PROFESSIONAL CONDUCT. The Committee on Professional Conduct shall consist of the five most recent past presidents of the Association. The senior member shall be Chairman. It shall investigate all complaints relating to or involving the ethical or professional practice of any member of The Medical Association of Georgia. All complaints or accusations against any member of The Medical Association of Georgia relative to irregular practice, excessive fees, habitual failure to respond to calls without adequate reason, extravagant or questionable statements made as witnesses in a court of law, or any act calling for disciplinary measures or investigations of a member, shall become the concern of this Committee. Complaints may be made by an individual patient, physician, board of censors of any local medical society, attorney, or any officer of a regularly constituted court of law. Upon receipt of notice of such complaint, the Committee, through its individual members or some competent person designated by it, shall immediately investigate the charges, and if the Committee is convinced that there is sufficient justification for a hearing the physician shall be requested to appear before at least three members of said Committee to answer charges. Such hearing shall be conducted in private and the source of information and charges will be divulged only at such hearing. No member of this Committee shall sit in a hearing involving a physician from his Councilor District.

After deliberation, the Committee shall have a choice of one of the four following dispositions:

1. Dismiss the case because of insufficient grounds for a legitimate complaint.
2. Attempt a satisfactory adjudication of the complaint.
3. Suggest to the physician changes in his conduct and relationship with his patients, in order that he may not bring unfavorable criticism upon his profession.
4. Refer to the Council of The Medical Association of Georgia all cases in which action by the Council is deemed necessary, together with recommendations as to disciplinary measures to be taken by the Council of The Medical Association of Georgia.

Nothing in this By-Lay shall be construed to prevent the selection and active participation in all the functions enumerated above by each component county society.

SECTION 3. (E), COMMITTEE ON HISTORY AND VITAL STATISTICS. It shall be the duty of the Committee on History and Vital Statistics to stimulate and promote the preparation of suitable articles on the history of the Association and its members, and shall recommend their publication to The Journal of the Association. It shall prepare memorials for deceased members, and arrange for their publication. It shall also report to the House of Delegates all new and eligible physicians who were licensed in the State during the past year indicating those who have become members of the Association. The Editor of The Journal and the President of the State Board of Medical Examiners shall be ex-officio members of this committee.

SECTION 3. (F) COMMITTEE ON PUBLIC HEALTH. The Committee on Public Health shall be composed of a chairman and a member of the Georgia State Department of Health appointed by the Executive Committee of Council of the Medical Association of Georgia and the chairman of each of the following Association committees: Industrial Health, Rural Health, Hospital Relations, Legislation, Medical Civil Preparedness, Mental Health, Crippled Children, Maternal and Infant Welfare, Geriatrics, Cancer, Insurance and Economics and Blood Banks. The chairmen of these committees shall then automatically be members of the Association's Public Health Committee and shall select an alternate member from each of their respective committees to represent them at Public Health Committee meetings in the absence of the chairman. It shall be the duty of the Public Health Committee to meet at least annually to hear reports from the Committee chairmen members so named, to correlate their activities and to act as a "clearing house" for any matters concerning public health. It shall also be the duty of the Public Health Committee to correlate these activities with the Georgia Department of Public Health.

SECTION 3. (G) COMMITTEE ON MATERNAL AND INFANT WELFARE. The Committee on Maternal and Infant Welfare shall be composed of three or more general practitioners, three or more obstetricians and three or more pediatricians. Terms of office shall be for a period of three years with one-third of the members appointed annually by the Executive Committee of Council. The committee shall regularly review and analyze the causes of all maternal deaths and perinatal losses occurring in the State for the purpose of recommending improvement. It shall also investigate conditions affecting maternal and infant care in Georgia and make recommendations concerning improvements thereof. The committee shall meet a minimum of twice annually.

SECTION 3. (H) COMMITTEE ON RURAL HEALTH. The Committee on Rural Health shall concern itself with improving medical service in the more sparsely settled areas in the State. It shall be composed of one member from each of the Councilor Districts comprising the Association as appointed by the Executive Committee of Council, and in addition, a member of the State Department of Public Health who shall serve as a member ex-officio without the right to vote. It shall investigate and make recommendations as to locating and staffing health centers and shall cooperate with the Better Health Council of Georgia, and the Council on Rural Health of the American Medical Association.

SECTION 3. (I), COMMITTEE ON INDUSTRIAL HEALTH. The Committee on Industrial Health shall be composed of five members. The committee shall confer with both labor and management in stressing the importance of preventive rather than curative medicine. It shall investigate and make recommendations concerning the initiation of programs designed to improve safe working conditions for employees and to solve other industrial health problems. It shall cooperate in all respects with the Council on Industrial Health of the American Medical Association.

SECTION 3. (J) COMMITTEE ON PUBLIC SERVICE. The Committee on Public Service shall be appointed by the Executive Committee of Council. It shall be the duty of the committee to integrate and publicize all approved plans and projects emanating from the Council and other standing and special committees of the Association. It shall consider all policies and make suggestions and recommendations for improving or changing such policies for the purpose of integration and publicizing. It shall develop additional projects for bettering understanding between physicians and the public.

SECTION 3. (K) COMMITTEE ON CANCER. The Committee on Cancer shall consist of one representative from the Association, one from each of the State-Aid Cancer Clinics, and one each from the Medical Colleges in the State who shall serve not less than three years, and the President shall ap-

point the chairman from among the members having the longest service. The chairman shall submit a list of physicians' names representing these groups for appointment by the President. An Executive Committee of this committee consisting of not less than six members shall be appointed by the President upon recommendation of the chairman.

It shall be the duty of this committee to represent the members of the Association in dealing with all matters pertaining to cancer, and in particular, it shall advise with the Division of Cancer Control of the Department of Public Health.

SECTION 3. (L) COMMITTEE ON INSURANCE AND ECONOMICS. The Committee on Insurance and Economics shall consist of not less than ten members, one from each Councilor district, to be appointed for a period of three years in rotation by the Executive Committee of Council and the Executive Committee shall appoint one of these chairman. The chairman may nominate lay persons with known interest in the field of insurance for appointment by the Executive Committee to serve in an advisory capacity.

SECTION 3. (M) COMMITTEE ON VETERANS AFFAIRS. The Committee on Veterans Affairs shall represent the Association in all matters pertaining to all veterans.

SECTION 3. (N) COMMITTEE ON CONSTITUTION AND BY-LAWS. The Committee on Constitution and By-Laws shall recommend to the House of Delegates any amendments which seem to be necessary or advisable. Proposed amendments shall be referred to this committee before action is taken by the House of Delegates.

SECTION 3. (O) COMMITTEE ON SCIENTIFIC EXHIBITS AND SCIENTIFIC AWARDS. The Committee on Scientific Exhibits and Scientific Awards shall have complete charge of all scientific exhibits and awards made by the Association or in the name of the Association for scientific exhibitors at the annual session.

SECTION 3. (P) COMMITTEE ON WOMAN'S AUXILIARY. The Committee on the Woman's Auxiliary shall cooperate with, advise and direct the Auxiliary in all matters concerning the Association.

SECTION 3. (Q) COMMITTEE ON HOSPITAL RELATIONS. The Committee on Hospital Relations shall pursue a continuing study of the relation of the medical profession to the operation of public and voluntary hospitals within this state and shall, when indicated, confer with the State Department of Health, the Georgia Hospital Association and all related organizations and make recommendations to this Association.

SECTION 3. (R) COMMITTEE ON CRAWFORD W. LONG MEMORIAL. The Committee on Crawford W. Long Memorial shall supervise matters pertaining to the Crawford W. Long Memorial and shall represent the Association in such matters subject to the approval of Council.

SECTION 3. (S) COMMITTEE ON MENTAL HEALTH. The Committee on Mental Health shall promote the welfare of the mentally ill in the State of Georgia and shall constantly seek means of improving care for the mentally ill in the State.

SECTION 3. (T) COMMITTEE ON GERIATRICS. The Committee on Geriatrics shall concern itself with the medical problems of the aged and chronically ill patient and pursue a continuing study of this problem as it affects the public health.

CHAPTER X.

Special Committees and Executive Secretary

SECTION 1. SPECIAL COMMITTEES. Special Committees may be created at any time when the necessity arises. Their necessity must be approved by the Council and they shall be appointed by the President.

SECTION 2. EXECUTIVE SECRETARY. The Executive Secretary shall be the administrative agent of this Association, of its Council and of all its committees. He shall be the executive

agent of the Association transacting its business under the direction of the Executive Committee of Council and shall be the directing manager of the Headquarters Office. He shall discharge the administrative functions of the Association not within the duties of the Association officers and committees and shall keep himself informed in regard to non-professional matters affecting the medical profession. He shall be responsible to the Executive Committee of Council for the execution and carrying out of the policies of the Association and in that connection shall perform all specific tasks committed to him by the committees, the Council and the officers of the Association.

The selection, terms of employment and salary of the Executive Secretary shall be determined by the Executive Committee of Council, subject to the approval of Council. The Executive Secretary shall be responsible to the Executive Committee of Council and the Executive Secretary shall prepare a report on the activity and status of the Headquarters Office for the Executive Committee of Council at each of their meetings to keep the committee informed at all times.

CHAPTER XI.

The Journal

SECTION 1. The Journal of the Medical Association of Georgia herein referred to as The Journal, shall be under the control and direction of the Council. It shall appoint an Editor and an Editorial Board annually and make any other provisions for the publication of The Journal; enumerate and define the powers and duties of the Editor or Editorial Board, or both; and fix the terms and conditions of their appointment.

SECTION 2. The Council may employ a Business Manager of The Journal and other personnel and fix the terms of such employment.

SECTION 3. All papers presented before the Annual Session shall be submitted to the Editor for consideration for publication in The Journal. Abstracts of transactions of the House of Delegates and Council shall be published as early as practicable. Records and notices of component county and district society meetings may also be published, and consideration given to the publication of papers presented before such meetings.

SECTION 4. The Executive Committee of the Council shall constitute the Publications Committee of the Journal.

CHAPTER XII.

Rules and Ethics

SECTION 1. The Principles of Ethics of the American Medical Association, this Constitution and By-Laws as now set forth or as may be hereafter amended and the standards of the profession in Georgia shall govern the conduct of the members of this Association.

SECTION 2. The deliberations of the Association shall be conducted in accordance with parliamentary usage contained in the then current edition of Robert's "Rules of Order, Revised," unless contrary to this Constitution and By-Laws.

CHAPTER XIII.

Amendments

These By-Laws may be amended at any Annual Session by a majority vote of the House of Delegates after the amendment has lain on the table for one day.

CHAPTER XIV.

On the adoption of this Constitution and these By-Laws all rules and regulations in conflict herewith are hereby repealed, provided that all officers, delegates and committeemen now in office shall continue their incumbency until their successors are duly elected and installed or chosen as herein provided.

106th Annual Session



Members of the Woman's Auxiliary seen at the MAG Communications and Information Center are Mrs. G. L. Calk, Mrs. C. W. Coolidge, Mrs. Gregory E. Flynn, and Mrs. Richard King, of Fulton County. Mrs. O. S. Cofer and Mrs. J. K. Fancher were in charge of pages. Mrs. E. A. Bancker was Auxiliary Convention Chairwoman.



Members of the House of Delegates register in the Academy of Medicine.



House Speaker, Thomas W. Goodwin, opens the First Session.



"Histerography" — Scientific Exhibits blue ribbon winner.



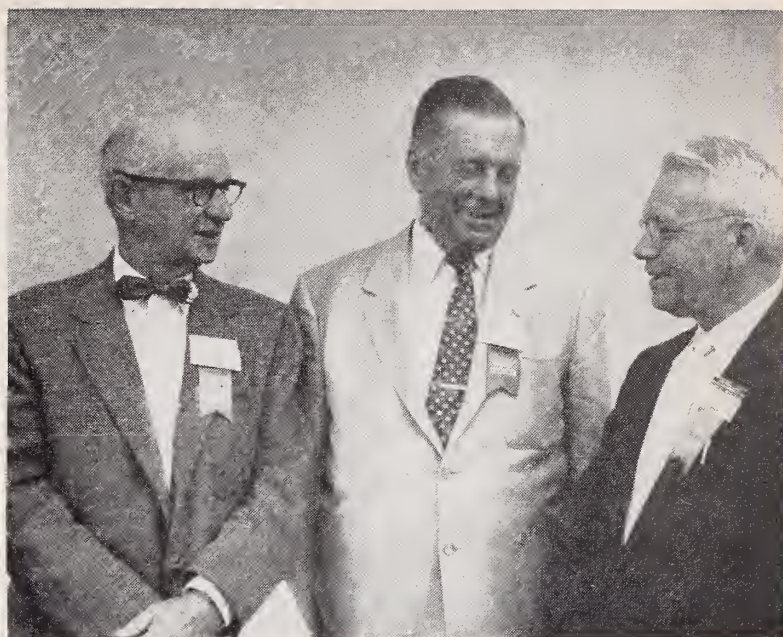
Dr. Charles Sterling Jernigan, of Sparta, was voted Georgia's 1956 "General Practitioner of the Year" by the Association. Dr. Jernigan is a Life Member, Oconee Valley Medical Society. More news of him is on p. 346.



Dr. W. Bruce Schaefer, Toccoa, is the President-Elect of the Medical Association of Georgia for the Year 1956-1957, having been elected by acclamation at the MAG's 106th Annual Session, May 13th-16th.

Medical Association of Georgia

Seen chatting at the Annual Session were AMA Delegates from the MAG, Charles H. Richardson, Sr., M.D., Macon; George F. Lull, M.D., of Chicago, Illinois, Secretary-General Manager of the American Medical Association; and H. Dawson Allen, Jr., M.D., Milledgeville, President of the Medical Association of Georgia.



Dr. Goodwin presided at the House of Delegates meetings.



Dr. Rumble presented a resolution for consideration by the Delegates.



Pictured above are Don F. Cathcart, M.D., 1956 President-Elect, Fulton County Medical Society; J. W. Palmer, M.D., an MAG Past President; and David Henry Poer, M.D., MAG Secretary-Treasurer.



Members and guests view commercial exhibits during recess.

THE ASSOCIATION

Executive Committee of Council

June 2, 1956, Macon, Ga.

THE EXECUTIVE COMMITTEE of Council meeting was called to order by Chairman J. W. Chambers, LaGrange, in the Pine Room of the Dempsey Hotel, Macon, Georgia, at 4 p.m., June 2, 1956.

Present were: Hal M. Davison, Atlanta, President; W. Bruce Schaefer, Toccoa, President-elect; H. Dawson Allen, Jr., Milledgeville, Immediate Past President; David Henry Poer, Atlanta, Secretary-Treasurer; J. W. Chambers, LaGrange, Council Chairman; and George R. Dillinger, Thomasville, Finance Committee Chairman; Edgar Woody, Jr., Atlanta, *JMAG* Editor; and Mr. Milton D. Krueger, Executive Secretary.

1956-57 — Committee Appointments — The Executive Committee of Council made the following appointments for the year 1956-57 of Association committee members, thus completing *MAG* 1956-57 Committee appointments previously made at the April 12, 1956 Executive Committee of Council meeting.

Legislation Committee—Appointed Eustace A. Allen, Atlanta, as vice-chairman of the Committee on Legislation to replace J. W. Chambers, LaGrange.

Medical Defense—Reappointed the members of the Medical Defense Committee as follows: W. L. Pomeroy, Waycross, chairman (term of 5 years); W. Bruce Schaefer, Toccoa (term of 4 years); Hal M. Davison, Atlanta (term of 3 years); David Henry Poer, Atlanta; and George R. Dillinger, Thomasville.

History and Vital Statistics—Appointed Purcell Roberts, Atlanta, as an additional member of this committee.

Maternal and Infant Welfare—Appointed Charles M. Mulherin, Augusta, chairman, with the former chairman, Peter Hydrick, College Park, to serve as a member.

Woman's Auxiliary—Reappointed this committee as follows: Shelley C. Davis, Atlanta, chairman; Walker L. Curtis, College Park; R. C. Major, Augusta; Edgar M. Dunstan, Atlanta; and Leo Smith, Waycross.

Public Service Committee—Appointed Charles D. Hollis, Jr. of Albany to serve on the Public Service Committee in place of George R. Dillinger, Thomasville.

Insurance and Economics—Appointed additional members to the Insurance and Economics Committee as follows: William Perrin Nicolson, III, Gainesville; Thomas E. Floyd, Griffin; and Rudolph F. Bell, Thomasville; and also voted to seek to have W. L. Pomeroy of Waycross remain on the Insurance and Economics Committee because of his loyal and valued service to this committee.

Mental Health—Appointed two additional members to the Mental Health Committee as follows: Richard E. Felder, Atlanta, and Russell Thomas, Americus.

Medical Civil Preparedness—Reappointed the Medical Civil Preparedness Committee as follows: Edgar M. Dunstan, Atlanta, chairman; Lee H. Battle, Jr., Rome; Perry P. Volpitto, Augusta; J. Fletcher Hanson, Macon; Thomas J. Ferrell, Waycross; Joseph S. Skobba, Atlanta; and Charles E. Dowman, Atlanta.

American Medical Education Foundation—Appointed Ben K. Looper, Canton, chairman of the AMEF Committee to replace the former Chairman, Arthur M. Knight, Jr., Waycross.

Blood Banks—Appointed Milton Freedman, Atlanta, as an additional member of the Blood Banks Committee.

Crippled Children—The Crippled Children Committee was reappointed by Executive Committee as follows: Jack C. Hughston, Columbus, chairman; F. James Funk, Jr., Atlanta; John L. Chandler, Jr., Augusta; Harold W. Muecke, Waycross; James W. Bennett, Augusta; W. G. Elliott, Cuthbert; M. F. Arnold, Hawkinsville; W. U. Clary, Savannah.

MAG and Woman's Auxiliary Roster—*JMAG* Editor, Edgar Woody, Jr., discussed the publication of the *MAG Roster* in January, and recommended that the *Woman's Auxiliary Roster* be separated from this January *MAG Roster*, and further that the *Woman's Auxiliary Roster* be printed separately in July prior to the printing of the *MAG Roster*. The advantages of this were discussed, and by general agreement the Executive Committee of Council, which also acts as the Publications Committee, approved unanimously the separation of the *MAG Roster* from the *Woman's Auxiliary Roster* and empowered Dr. Woody to handle the details of this change.

Executive Committee Meeting Date — By unanimous agreement the Executive Committee of Council voted to hold its monthly meeting on the first Sunday of each month at 6 p.m. in the Headquarters Office of the Association, Atlanta. It was further noted that when Council meets during the month, an Executive Committee meeting would not be necessary.

Chairman Chambers adjourned the meeting at 5:40 p.m.

Council of the MAG

June 2, 1956, Macon, Ga.

The June 2-3, 1956, meeting of the Council of the Medical Association of Georgia was called to order by J. W. Chambers, Chairman, at 9 p.m. in the Pine Room of the Dempsey Hotel, Macon.

Council members present included: Hal M. Davison, Atlanta, President; W. Bruce Schaefer, Toccoa, President-elect; H. Dawson Allen, Jr., Milledgeville, Immediate Past President; Carl C. Aven, Marietta, 1st Vice-President; Bernard P. Wolff, Atlanta, 2nd Vice-President; David Henry Poer, Atlanta, Secretary-Treasurer; Thomas W. Goodwin, Augusta, House of Delegates Speaker; Lee Howard, Sr., Savannah; George R. Dillinger, Thomasville; W. G. Elliott, Cuthbert; J. W. Chambers, LaGrange; J. G. McDaniel, Atlanta; Henry H. Tift, Macon; James N. Hicks, Brunswick (vice-councilor acting as councilor in the absence of F. G. Eldridge, Valdosta); Charles R. Andrews, Canton.

Also present were C. H. Richardson, Sr., Macon, AMA Delegate; Edgar Woody, Jr., Atlanta *JMAG* Editor; Chris J. McLoughlin Atlanta, Public Service Committee Chairman; and, Mr. Milton D. Krueger, Executive Secretary.

Minutes—Chairman Chambers called for reading of the minutes of the final meeting of the 1955-56 Council, May 12, 1956, Atlanta. After the minutes were read, by general agreement, upon the recommendation of H. Dawson Allen, Jr., the Executive Secretary was instructed to footnote the Talmadge Hospital Memorial Policy Resolution contained in those minutes to indicate that this resolution was changed by the House of Delegates after its introduction into the House by the Council. With this addition, the May 12, 1956, Council meeting minutes were approved. Mr. Krueger read the minutes of the organizational meeting of

the 1956-57 Council, May 16, 1956, Atlanta, and on motion duly made and seconded, these minutes were approved.

AMA Delegates Resolutions—Chairman Chambers called on C. H. Richardson, Sr., representing the AMA Delegates, to present resolutions passed by the MAG House of Delegates for transmission to the AMA House of Delegates. These resolutions were: (1) Sears Roebuck Foundation; (2) AMA Regional Meetings; (3) AMA Dues; and (4) Automobile Safety. The resolutions were read and accepted as information by the Council members; there was no need for Council action, the resolutions having been approved by the House of Delegates.

Review and Appointments to Council Committees 1956-57—Chairman Chambers called on the Council to review and make any new appointments to the Council Committees for the year 1956-57. These committees as appointed or reappointed, with the unanimous approval of Council, are as follows:

Finance—George R. Dillinger, Thomasville, chairman; J. G. McDaniel, Atlanta; and D. Lloyd Wood, Dalton.

Legal Counsel—Hal M. Davison, Atlanta, chairman; W. Bruce Schaefer, Toccoa; Charles S. Jones, Atlanta; and Bernard P. Wolff, Atlanta.

Reserve Fund—W. G. Elliott, Cuthbert, chairman; Henry H. Tift, Macon; and George R. Dillinger, Thomasville.

Cultists—Thomas W. Goodwin, Augusta, chairman; Henry H. Tift, Macon; and F. G. Eldridge, Valdosta.

Institution-Physician Relations—Henry H. Tift, Macon, chairman; Milford B. Hatcher, Macon; W. W. Bryan, Atlanta (Radiology); Lester Rumble, Jr., Atlanta (Anesthesiology); G. Darrell Ayer, Atlanta, (Pathology); and Lee Howard, Sr., Savannah, *Ex-officio*.

MAG-Hospital Association—Charles R. Andrews, Canton, chairman; Luther H. Wolff, Columbus; Mr. George H. Stone, Thomasville and Mr. Daniel E. Gay, Savannah.

Headquarters Building—Carl C. Aven, Marietta, chairman; John W. Turner, Atlanta; and Hal M. Davison, Atlanta.

Annual Session Committee—J. G. McDaniel, Atlanta, chairman; Henry H. Tift, Macon; J. W. Chambers, LaGrange; David Henry Poer, Atlanta; and George R. Dillinger, Thomasville.

It was also recommended and unanimously approved that the Hardman Award Committee be deleted and that the Executive Committee of Council act in the capacity of the former Hardman Award Committee of Council. It was further recommended and duly approved that the matter of annual session lectureships be referred to the Executive Committee of Council for study, so that the Association may promulgate "ground rules" for handling of lectureships at annual sessions of the Association.

1957 Savannah MAG Annual Session—A resolution submitted to the House of Delegates by Ruskin King in behalf of the Georgia Medical Society concerning a shipboard cruise meeting for the 1957 MAG Annual Session and Reference Committee No. 4's recommendation that said resolution be referred to the Council of the Medical Association of Georgia as approved by the House, was read. On motion it was recommended that because of foreseeable difficulties in scheduling such a cruise meeting, the meeting be held on land in Savannah similar to past annual sessions.

In conjunction with the recommendation of the Annual Session Committee of Council, it was recommended that the Association hold the 1957 Savannah Annual Session at the DeSoto Hotel on April 21, 1957. This date and place were then approved.

AMA Secretary's Letter—Secretary David Henry Poer then read remarks of commendation carried in the AMA Secretary's letter over the signature of George F. Lull, Secretary-General Manager of the American Medical Association, concerning the Medical Association of Georgia's senior

AMA Delegate, Charles H. Richardson, Sr. of Macon. A vote of commendation was given Dr. Richardson for his service to the profession in Georgia.

Mental Health Clinic—After some discussion, on motion the Executive Secretary was requested to write Muscogee County Medical Society asking them for information concerning the operational plans for the Sarah and William Bradley Mental Health Clinic. This motion was duly approved.

The Chairman of Council recessed the meeting with the instruction that it would reconvene at 8 a.m., June 3.

June 3, 1956

THE JUNE 2, 1956, reconvened meeting of Council was called to order at 9 a.m., June 3, 1956 in the Civic Room of the Dempsey Hotel, Macon, by Chairman J. W. Chambers.

Attendance was the same as on Saturday.

Hospital Care Study Commission—Milford B. Hatcher, Macon, Chairman of the MAG Hospital Committee and member of the Georgia Legislature's Hospital Care Study Commission reported on his activity in representing the Association at the recent meeting of the Hospital Care Study Commission. After a complete discussion of the aims and objectives of this commission, Dr. Hatcher asked for comment. On motion the Council went on record as approving the plans of the Hospital Care Study Commission in principle, pledged cooperation with the Hospital Care Study Commission, and further recommended that any specific commitments of the Association should be referred to the full Council for study. The motion further recommended that Dr. Hatcher be commended for his activity in this area. The motion was approved.

On motion it was recommended that the Medical Association of Georgia underwrite a dinner at the September 13, 1956, meeting of the Hospital Care Study Commission and that any additional funds up to \$300 be allocated to further the commission's program under the direction of Dr. Hatcher. This motion was approved.

Legal Counsel—Certain resolutions from the May 15 House of Delegates Session concerning legal counsel for physicians regarding the status of medical practice in the State of Georgia were referred to the Legal Counsel Committee to be reported on at the September 1956 Council meeting.

Executive Committee of Council Committee Appointments—It was recommended that the appointments for MAG Committees, made by the MAG Executive Committee of Council on June 2, 1956, be approved by the Council. This motion was approved.

Workmen's Compensation—A resolution introduced before the House of Delegates May 13-16, 1956, on Workmen's Compensation and the reference committee recommendation which referred this resolution to Council as approved by the House of Delegates was read. It was recommended that the Chairman appoint a committee to study this problem and make recommendations at the September 1956 meeting of Council.

Medical Defense—After discussion of the medical defense provisions in the MAG Constitution and By-Laws, it was moved that the membership of the Medical Association of Georgia be notified as to why the privileges of medical defense had been altered, be informed about the new provisions of medical defense, and be queried as to whether or not they carry their own professional liability insurance. This motion was also unanimously approved.

History and Vital Statistics Request—The request concerning the publication of a history of Georgia medicine and the author's remuneration therefor, made by J. Calvin Weaver of the History and Vital Statistics Committee in his 1956 Annual Report, which was duly approved at the May

15, 1956, House of Delegates meeting, was discussed. By general agreement this matter was referred to Dr. Davison, and it was also moved that a report be prepared on this matter by the September 1956 meeting of Council.

Milledgeville State Hospital Study Commission—It was moved that the Chairman of Council be empowered to appoint two psychiatrists to the Milledgeville State Hospital Study Commission, created by the Georgia Legislature, to assist this commission in ascertaining the advisability of the transfer of the control of Milledgeville State Hospital. This motion was approved.

Georgia State Employees Physical Examination—A communique from the Georgia Attorney General's Office was read concerning the request of the Georgia State Personnel Department for a member or members of the Medical Association of Georgia to assist in the promulgation of reasonable rules and regulations for physical examinations as a prerequisite for employment by the State of Georgia. It was recommended that the Chairman of Council make this appointment.

District Dues—A communique from T. Schley Gatewood, Secretary of the Third District Medical Society, concerning the collection of district medical society dues was read to the members of Council. It was recommended that the Executive Secretary write Dr. Gatewood to clarify the part that the Headquarters Office can play in assisting the district society in its collection of dues. It was emphasized that the Medical Association of Georgia does not have the right to collect dues directly from any member for any purpose.

Talmadge Hospital House of Delegates Resolution—Mr. Krueger read letters sent on May 30 to Mr. Harmon Caldwell, Chancellor, University System of Georgia; Edgar R. Pund, President, Medical College of Georgia, and Robert

Arnold, Chairman, Board of Regents, University System of Georgia. These letters petitioned the Board of Regents and the president of the Medical College of Georgia along certain lines recommended in a House of Delegates resolution passed at the May 15, 1956, Session, concerning the operational policies of the Eugene Talmadge Memorial Hospital.

Edgar Woody, Jr., suggested new methods for helping defray the cost of Medical education; Council approved their being referred to the MAG Medical Education Committee for consideration.

Annual Session Numbering—On the basis of documented evidence, it was approved that the Savannah 1957 Annual Session of the Medical Association of Georgia be referred to as the 103rd Annual Session, thus correcting the inaccurate numbering of our annual sessions to date.

Ninth District Vice-Councilor—It was recommended that the Ninth District be requested to elect a vice-councilor on an interim basis or that the Executive Committee of the Ninth District Medical Society act in the District's behalf in complying with this request.

Next Council Meeting—After discussion concerning a September Council meeting in Savannah or in Brunswick, it was duly moved, seconded, and approved that the date, time, and place of the September meeting of Council be referred to the Executive Committee and that they consider both Savannah and Brunswick.

By unanimous motion and a rising vote of thanks, the Council of the Medical Association of Georgia expressed its sincere appreciation to Dr. and Mrs. Henry H. Tift of Macon for their hospitality on the occasion of this Council meeting, and instructed the Executive Secretary to record the same.

There being no further business Chairman Chambers adjourned the meeting at 11:10 a.m.

TB-Like Disease Increasing

WARNINGS OF AN "alarming increase" in the incidence of a newly recognized, tuberculosis-like disease were sounded at the recent annual meeting of the National Tuberculosis Association and the American Trudeau Society.

Three reports emphasized a growing recognition of the pathogenicity of atypical acid-fast bacilli, both chromogenic (color producing) and nonchromogenic, many of which resemble the tubercle bacillus and are often confused with it.

These organisms are regarded by some as possible mutants or overgrowths due to chemotherapy. They are now being frequently detected because of more precise and more generally used culture techniques, in addition to routine sputum smears, the speakers noted.

The largest of the studies revealed, for example, an eight-fold increase in the reported incidence of "chromogenic" infections among nontuberculous pulmonary patients in the last three months of 1955, as compared with the same period in the previous year.

This finding was reported by Dr. Marie L. Koch, a member of the research team that conducted the study at the VA Hospital, Wood, Wisconsin.

At the hospital, 298 "chromogenic" cases were found, in both nontuberculous and tuberculous patients. Of these, 125 were considered to have persistent infections difficult to treat.

Virulence Confirmed

A similar note of caution was voiced by Dr. Horace E. Crow, who reported on a survey of patients at the Battey

State Hospital, Rome, Ga. This study disclosed that 69 persons—mostly over 30 years of age—had pulmonary lesions associated with atypical acid-fast bacilli.

"Although these individuals responded poorly to chemotherapy, they appear to be less infectious to others than typical tuberculous patients," Dr. Crow pointed out.

The third report confirmed the virulence of one species of nonchromogenic atypical, acid-fast bacillus—*Mycobacterium fortuitum*—isolated from patients with pulmonary inflammatory disease. Dr. Daniel S. Kushner of Cook County Hospital, Chicago, described studies in which the organism was found to be pathogenic in mice and produced sensitization of rabbits. Skin tests did not cross react with human tuberculin.

These recent investigations, the researchers said, raise major problems of immediate concern to physicians. Among them are:

Immediate Problems

The need for improved recognition of this new disease entity through better diagnostic methods, with special stress on routine use of cultures in patients with pulmonary lesions.

A search for more effective therapeutic agents against the atypical organisms.

Possible redefinition of tuberculosis, now considered a disease caused solely by the tubercle bacillus. This raises legal and other questions hinging on public health restrictions and medical insurance contract exclusions.

ANNOUNCEMENTS

American Board of Obstetrics and Gynecology Applications for Certification—Applications for the 1957 Part I examinations are now being accepted; deadline for receipt of application is Oct. 1, 1956. Current bulletins outlining present requirements may be obtained by writing: Robert L. Faulkner, M.D., American Board of OB and GYN, 2105 Adelbert Road, Cleveland 6, Ohio.

The National Institute of Neurological Diseases and Blindness has initiated a program of special clinical traineeships for those who have completed residency training in a medical specialty and desire further training for careers as clinical investigators and educators in fields of neurological and sensory disorders. If interested write to the Chief, Extramural Programs, National Institute of Neurological Diseases and Blindness, National Institutes of Health, Bethesda 14, Md.

The American Academy of Obstetrics and Gynecology has been renamed the American College of Obstetricians and Gynecologists, Dr. Ralph E. Campbell, Madison, Wisconsin, President of the College has announced. The change became official May 11, 1956. Its headquarters are located at 116 South Michigan Ave., Chicago 3, Ill.

First Inter-American Conference on Occupational Medicine and Toxicology—Miami, Fla., September 3 to 7, 1956. The University of Miami School of Medicine will sponsor the conference jointly with the University of Havana School of Medicine; the official language of the program will be Spanish. For further information, write to Dr. Homer F. Marsh, Dean of the School of Medicine of the University of Miami and General Chairman of the meeting.

University of Illinois Annual Assembly in Otolaryngology—Chicago, Ill., October 1-7, 1956. Interested physicians should write direct to the Department of Otolaryngology, 1853 West Polk Street, Chicago 12, Ill.

Examinations for Fellows of the International College of Surgeons—Examinations will be held in Chicago, July 23-24 and October 29-30. Oral conferences will be held on August 6 and October 22. For details, write to the Secretary of the Qualifications Council, International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, Ill.

Southeastern Surgical Congress 1957 Prize Scientific Paper Award—The best unpublished contribution on surgery or

allied subjects will be awarded \$100.00 and expenses for the author to attend the annual meeting in St. Petersburg, Fla. April 1-4, 1957. Contest open to AMA members in the Southeast. Three copies of the paper should be sent to the Councilor of the state in which the resident is living before December 1, 1956. For further information write to Dr. A. H. Letton, Chairman, Scientific Paper Award Committee, 701 Hurt Bldg., Atlanta 3, Ga.

DEATHS

CECIL HOWELL BLACKBURN, Conyers, died June 1956; he was 46 years old at the time of his death. Dr. Blackburn died while driving his automobile; it was presumed that the cause of death was a heart attack.

Funeral services were held at St. Thomas More Roman Catholic Church, with burial in Westview Cemetery, Atlanta.

Survivors include his wife; a son, Cecil Blackburn, Jr.; two stepsons, Michael and Cleve Morrison; and his mother, Mrs. Pearl Blackburn, all of Conyers.

WILLIAM HENRY BROOKS, Monticello, Utah, formerly of Lindale and Rome, died at his home on May 4, 1956, of a heart attack. Dr. Brooks was 39 years of age.

A native of Rome, Dr. Brooks attended Rome public schools and graduated from Wake Forrest College and the Bowman Gray School of Medicine, Winston-Salem, N. C. He practiced medicine in Lindale from April 1, 1950, to January 1, 1952, at which time he moved to Rome where he practiced until June 1955.

Survivors include his wife, the former Miss Evelyn Hatcher; three daughters and two sons. One of Dr. Brooks' four brothers surviving is Edwin Brooks of Calhoun.

Funeral services were held at the Westminster Presbyterian Church, Rome, with interment in Sunset Hill Memorial Gardens.

WILLIAM BARRON CRAWFORD, SR., Savannah, died on April 17, 1956; he was a Life Member of the Medical Association of Georgia.

A native of Savannah, Dr. Crawford was a graduate of Savannah High School. He entered Columbia University in 1896 and was graduated three years later with the degree of Doctor of Medicine. He interned at Roosevelt Hospital and was resident physician in obstetrics at Presbyterian Lying-In Hospital in New York before returning to Savannah in 1901 to begin his private

practice of medicine and surgery. He served in the U. S. Army Medical Corps during World War I.

Dr. Crawford practiced medicine for 55 years in Savannah and kept his office open until two months prior to his death. He was associated with St. Joseph's Hospital for many years, serving as chief of staff for 27 years; and he was instrumental in the founding of the hospital's nursing school over 50 years ago.

He was a member and past president of the Georgia Medical Society and a member of the First District Medical Society. In 1954 he was honored by the Hibernian Society for his 50 years of service by being made an honorary member of the society. He was also a member of the Sons of Confederate Veterans and the Knights of Columbus.

Surviving Dr. Crawford are his son, W. B. Crawford, Jr., Savannah; two daughters; a sister and a brother.

Funeral services were held at the Cathedral of St. John the Baptist; members of the Georgia Medical Society were honorary pallbearers. Burial was in Bonaventure Cemetery, Savannah.

LEIGHTON ALEXANDER SMITH, Quitman, died on May 7, 1956, at the age of 64. He had been ill for 10 days.

A native of Bethune, S. C., Dr. Smith came to Quitman in 1912. He served the U. S. Army Medical Corps in World War I. He was a charter member of the Quitman Kiwanis Club and a member of the Presbyterian Church, Brooks County Medical Society, and the Shrine.

Dr. Smith was married to the former Miss Augusta Guerry who survives him with two daughters, Mrs. Vereen Bell, Durham, N. C., and Miss Alexa Smith, Quitman. He is also survived by two brothers as well as several nieces and nephews.

SOCIETIES

The **THIRD DISTRICT MEDICAL SOCIETY** met on April 26, 1956, at the Memorial Building of Veterans' State Park on Lake Blackshear near Americus. John Gallemore, Perry, president, presided. Flint Medical Society was host. Speaking at the meeting were Waddell Barnes, Milford B. Hatcher, and L. E. Dickey, Jr., all of Macon; and Mack Sutton, Albany. Following the scientific session, the society met with the auxiliary for a social hour and dinner.

The **FIFTH DISTRICT MEDICAL SOCIETY** met at the Academy of Medicine, Atlanta, on April 19, 1956, to hear a lecture by Charles Hoyt Burnett, professor of medicine and head of the medical school at the University of North Carolina. Dr. Burnett spoke on "Problems of Assessment and Management of Bright's Disease."

(Societies)

The June meeting of the BIBB COUNTY MEDICAL SOCIETY was held on June 5, 1956, at Pinebrook Inn, Macon. Refreshments were served from 7:00 p.m. until dinner at 7:45. The scientific session featured a symposium on "The Radiological Aspects of the Acute Abdomen and Gastro-intestinal Tract Bleeding," presented by Max Mass, Herbert M. Olnick, Robert Cato, and William Somers, Macon.

The COBB COUNTY MEDICAL SOCIETY officers held Open House at the home of Dr. and Mrs. H. D. Meaders on May 24, 1956, for all members of the society and their wives; about 100 guests called between 8 and 10 o'clock. Officers of the society are E. P. Inglis, Wilbur Clonts, and H. D. Meaders.

The DOUGHERTY COUNTY MEDICAL SOCIETY met on April 26, 1956, to hear a lecture by R. L. Sanders, of Memphis, who specializes in gastrointestinal surgery. He spoke on gall-bladder ailments and prefaced his talk with remarks on the role of the physician in the elongation of the span of life.

The GEORGIA MEDICAL SOCIETY held its regular monthly meeting on June 12, 1956, in the Society's Hall, 612 Drayton Street, at 8:30 p.m. The guest speaker for the meeting was Eleanor Easley, of Duke University, who read a paper on "Problems Commonly Found in Obstetrics and Gynecology;" and M. M. Schneider, Savannah, presented a case report.

The regular meeting of the HABERSHAM COUNTY MEDICAL SOCIETY was held at the Commercial Hotel, Cornelia, on May 3, 1956, at 8:00 p.m. After dinner with the Woman's Auxiliary, the meeting was called to order by Austin J. Walter, who presided in the absence of the president. The society voted to donate to the American Medical Education Foundation the sum of \$100.00. Exum Walker, Atlanta, gave a lecture on "Management of Neurosurgical Emergencies."

The THOMAS-BROOKS MEDICAL ASSOCIATION held its quarterly meeting on June 21, 1956, at the Archbold Memorial Hospital in Thomasville. The social hour at 5:00 p.m. was followed by dinner and scientific meeting. The program consisted of a paper on "Surgery of the Aorta," presented by John M. Howard, professor of surgery, Emory University.

At the WARE COUNTY MEDICAL SOCIETY meeting on June 7, 1956, William S. Boyd, Augusta, was the principal speaker. He discussed "Common Female Operations—Indications

and Contraindications." Dr. Boyd has served as assistant clinical professor of obstetrics and gynecology for the past 10 years at University Hospital, Augusta, and prior to coming to Augusta he served on the staff of Armstrong College in Savannah.

PERSONALS

When the newly elected Honorary Member of the MAG, WILLIAM S. JONES, of Menominee, Michigan, came to Georgia, it was really a homecoming for the native Georgian who is now president of the Michigan Medical Association. Dr. Jones was born in Jeffersonville and is a graduate of the University of Georgia. He has lived in Menominee now for 40 years, where he has limited his practice to EENT.

Georgia's State Aid program for medical students will begin paying off for the state this summer when at least four physicians hang out their shingles in rural communities. By 1959 the program will be sending 25 doctors each year to rural communities of the state where the need for doctors is serious. The four physicians beginning practice this year are as follows: Richard L. Nutt of Griffin, who began practice in Jeffersonville about July 1. Dr. Nutt is married and the father of four children; he served his internship in Spartanburg, S. C. Jack W. Whitworth, who interned at an Athens hospital, is returning to his hometown of Greenville to practice. John R. Harrison of Macon, who interned in Macon, begins his practice at Millen in July. Sterling A. Harris of Decatur, who interned at Crawford W. Long Memorial Hospital in Atlanta, will practice in Buford. Dr. Harris has just been awarded a Sears-Roebuck Foundation grant to aid him in building a new medical facility for the community of Buford.

Two other physicians, besides Dr. Harris, have been awarded Sears-Roebuck Foundation grants to aid them in establishing medical facilities or practices in their localities. They are Ray D. Webb of Springfield and Park L. Gerdine of Quitman.

First District

Leland D. Stoddard, Augusta, was the principal speaker at the meeting of the First District Association of Georgia Funeral Directors on May 6th in Springfield. CHARLES T. BROWN, Guyton, and H. L. SCHOFIELD, JR., Savannah, also attended and took part in the discussion following Dr. Stoddard's address. The Funeral Directors Association is developing a program of cooperation with the doctors of more study, by autopsy, to discover new treatments and cures for various types of illness.

ELLISON R. COOK, III, Savannah, has proposed the employment of a full-time city-county physicians for Chatham County to care for indigent medical patients as well as city and county employees who are hospitalized. Dr. Cook, who is a City Alderman, said that the health and welfare departments feel that a full-time doctor is needed.

At the meeting of the Georgia State Society of American Medical Technologists, June 3, 1956, ALBERT M. DEAL, Statesboro, president of the State Board of Medical Examiners, addressed the executive session on Public and Professional Relations.

ALBERT J. KELLEY, Savannah, has been elected chief of obstetrics and gynecology at Memorial Hospital of Chatham County. Dr. Kelley has been practicing in Savannah since 1937. He is a graduate of Northwestern University, where he received his B. S. and M. D. degrees, and he served his residency at Buffalo City Hospital. He has been chief of gynecology at the Savannah Tumor Clinic since 1941. He is a member of the South Atlantic Association of Obstetrics and Gynecology and is immediate past president of the Georgia State Association of OB and GYN. He has served as president of the Chatham-Savannah Health Council, vice-president of the Georgia Mental Health Association, and is currently chairman of the Chatham County Board of Health.

NORMAN E. TITUS, Savannah, announces the removal of his office from 112 West Jones Street, Savannah. His new address is, as of June 1st, Apartment 18, 4 Green Acres Drive, Verona, New Jersey.

Second District

HENRY K. JARRETT, Tifton, has recently been indoctrinated into the Tifton Rotary Club. Dr. Jarrett, a urologist, recently moved to Tifton to practice. During the same meeting C. S. PITTMAN, SR., was commended for having missed only one meeting in the 20 years of existence of the Tifton Rotary Club.

EARLE E. MOSELEY, Donalsonville, has been named an alternate delegate to the National Democratic Convention.

Robert D. Smith, Tifton, announces the opening of his office for the practice of general medicine on Fourth Street in the Zimmerman Building, Tifton. Dr. Smith, who is a native of Tifton, has just been released from the Air Force after three years' service. He is married to the former Miss Maxine Vincent of Birmingham, Ala., and they have one son, Michael Glenn. Dr. Smith is a graduate of the Univer-

(Personals)

sity and the Medical College of Georgia. He interned at Walter Reed Hospital, Washington, D. C.

FRANK THOMAS, SR., Albany, has announced his retirement from the active practice of medicine. Dr. Thomas is a graduate of the Emory University School of Medicine and has practiced medicine for 43 years. He is chief emeritus of the Department of Obstetrics at the Phoebe Putney Hospital and will continue to take an active role in an advisory and planning capacity for the hospital. Dr. Thomas has two children, FRANK THOMAS, JR., Albany, and Mrs. LeConte Talley, Augusta, who has a son in medical school.

Third District

C. C. GOSS, Ashburn, has terminated his association with Goss' Clinic in Ashburn to accept a position with the Veterans Administration in Atlanta. He assumed his new position on May 15th. Dr. and Mrs. Goss and their two children, John and Gwen, will make their home in McDonough, and he will commute to the VA hospital.

LOUIS A. HAZOURI, Columbus, spoke at the meeting of the Dougherty County Medical Society on May 31, 1956. He praised the automobile industry in providing safety features in automobiles to reduce head injuries, but he emphasized that the cure for all head injuries is prevention which can only be accomplished by public knowledge of the tragedies on the highway and more stringent police enforcement of traffic laws. He discussed the treatment of head injuries and modern techniques of anesthesia and antibiotics.

A permit has been issued for JACK C. HUGHSTON, Columbus, to have constructed a building to house an orthopedic clinic at 1550 13th Avenue, Columbus. The building will have space for four offices.

James W. Reynolds, formerly of Macon, is now associated with WOODROW GOSS, Ashburn, at the Goss Clinic. A native of Greensboro, Dr. Reynolds is a graduate of the Emory University School of Medicine. He interned at St. Louis City Hospital and served 18 months in the U. S. Army. For the past year he has been resident physician at Macon Hospital.

On May 14, 1956, a portrait of BERT TILLERY, Columbus, was unveiled at St. Francis Hospital where more than 100 of his friends gathered to pay tribute to "their doctor." In addition, \$1,000 was presented in honor of Dr. Tillery for a school of nursing for the hospital. Receiving the portrait and donation for the school of nursing, Sister Laurentine, administrator of St.

Francis Hospital, said that he, as a consultant for the hospital, "never asked for anything to benefit himself, but only for things to benefit the people. What success we've made is due Dr. Tillery."

Fourth District

GRADY E. BLACK, Griffin, announces the removal of his office to 567 South 9th Street, Griffin, for the practice of pediatrics.

H. A. Foster, formerly of Heflin, Alabama, has moved to Griffin to take over the practice of JOEL E. COX who is going to Charity Hospital, New Orleans, for a post graduate course in obstetrics and gynecology. Dr. Foster and his family are living at 861 Bieze Street.

WILLIAM L. HUTCHINSON, LaGrange, is a co-chairman of the LaGrange Region of Presbyterian College's Diamond Jubilee Development program. The region is working to raise \$25,000 for the college in Clinton, S. C.

BEN H. JENKINS, Newnan, recently addressed the Newnan Kiwanis Club, telling about his recent tour of Russian clinics and hospitals. He described the dire poverty existing among the Russian people, particularly in Leningrad, one of the country's major seaports, and marveled at a Russian civilization which embodies several of the world's most famous art museums, operatic productions, and magnificent ballets, yet has such poor housing and other facilities for the masses of people. He feels that Russian production and technical know-how is diverted toward strengthening the nation's capital goods and military preparedness.

ALEX D. JONES, Griffin, was the speaker at a recent meeting of the Griffin-Spalding County Hospital Auxiliary. He discussed the film, produced in color with sound, by the Griffin-Spalding County Hospital Board and Hospital Authority telling the history of the hospital in Griffin. Dr. Jones wrote the scenario for this film which is to tell people about their hospital and the relations of the hospital to the community.

HARRY C. KING, WILLIAM R. KING, JR., and Lamar King, Griffin, have named their new office building at 708 South 8th Street the Russ King Memorial Building in memory of their father, the late William Russell (Russ) King who practiced medicine in and around Tennille from 1912 until his death in 1950. Dr. King, Sr., was a graduate of the Emory University School of Medicine as were his two older sons, Harry and William, Jr.; Lamar King is a graduate of the Medical College of Georgia and has just completed four years' residency in ur-

ology at Grady Memorial Hospital in Atlanta.

A drive to raise funds for the Valley Hospital in West Point and the George H. Lanier Memorial Hospital in Langdale has been started in honor of C. O. WILLIAMS, West Point, and W. L. Marshall, Langdale, Alabama. The fund is known as the Marshall-Williams Fund and is a tribute to a total of 100 years of service by the two Valley physicians who have each been made Life Members of their respective state medical associations recently.

HART S. ODOM, formerly of Woodbury and Greenville, has joined the Muscogee County Department of Public Health.

Dr. and Mrs. J. W. PURCELL, JR., Covington, announce the birth of a son, James Michael, on April 22, 1956.

T. A. SAPPINGTON, Thomaston Medical Examiner; ALEX P. JONES, Spalding County Medical Examiner, and Herman D. Jones, Ph. D., head of the Georgia State Medical Examiners, participate in a group discussion relating to all phases of medical examination cases at the recent meeting of the Georgia State Medical Examiners in Atlanta. Out-of-state guest speakers taking part in the meeting included Russell S. Fisher, Chief Medical Examiner of Maryland; Geoffrey T. Mann, Chief Medical Examiner for Virginia; and Arnold F. Strauss, pathologist in the office of the Chief Medical Examiner of Norfolk, Va.

Fifth District

THOMAS J. ANDERSON, JR., Atlanta, was elected to associate membership in the American College of Physicians at its 37th Annual Session at Los Angeles, April 16-20, 1956.

CARL C. AVEN, Atlanta, was the guest speaker at the annual meeting of the South Central Georgia Tuberculosis Association at Pineview General Hospital in Valdosta held on May 1, 1956. Dr. Aven talked on the new trends in the treatment of tuberculosis.

Mary Elizabeth is the name given to the daughter born to Dr. and Mrs. ERNEST W. BEASLEY, JR., Atlanta, on May 9, 1956. Mrs. Beasley is the former Miss Ann Jeffreys.

At the meeting of the Southern Neurosurgical Society held in Jacksonville, Florida, on March 23 and 24, 1956, DONALD S. BICKERS, Atlanta, was elected to membership in the society.

Five physicians of the U. S. Public Health Service Communicable Disease Center in Atlanta were awarded the Billings Silver Medal for an exhibit on laboratory techniques in the diagnosis

(Personals)

of communicable diseases at the AMA convention in Chicago in June.

They are R. B. HOGAN, M. M. Brooke, G. R. COOPER, D. S. MARTIN, and M. Schaeffer.

JOHN D. CAMPBELL, Atlanta psychiatrist, was the guest speaker at the May meeting of the Hoganville Parent-Teacher Association.

RIVES CHALMERS, Atlanta, spoke to the members of the Woman's Auxiliary to the Cobb County Medical Society on "Mental Health—The Citizen's Opportunity" at their May meeting.

Monday night, May 7, 1956, was THOMAS MIXON EZZARD Night at the Lions Club Meeting in Roswell. The program was presented as the television program "This Is Your Life," and nearly 100 north Fulton County residents jammed the Roswell VFW clubhouse to honor Dr. Ezzard and take note of his 43 years of service to the community. The physician, who celebrated his 74th birthday last Saturday, was given a plaque by the Lions Club "in recognition of his faithful service to the community and to humanity."

DAVID F. JAMES, Atlanta, was one of the guest speakers at the Annual Meeting of the South Carolina Medical Association; Dr. James moderated a panel on "The Uses and Abuses of ACTH and Cortisone" on May 16, 1956.

JAMES T. KING, Atlanta, attended the meeting of the American Laryngological, Rhinological, and Otological Society in Montreal, Canada, May 15, 16, and 17, 1956. He delivered a paper on "Tonsillectomy: Two Millennia of Hemorrhage and Controversy."

BERNARD S. LIPMAN, Atlanta, was recently elected to fellowship in the American College of Physicians.

JACK C. NORRIS, Atlanta, has been sworn in for his third three-year term as a member of the State Workmen's Compensation Board. Others recently installed are MARCUS MASHBURN, SR., Cumming, and F. KELLS BOLAND, JR., Atlanta.

R. E. ROBERTS has announced the opening of his office at 408 South Church Street, East Point, for the practice of internal medicine. Dr. Roberts is a graduate of the Medical College of Georgia and did post graduate work at Macon and Piedmont Hospital in Atlanta. For the past two years he has been in the Army Medical Corps.

Dr. and Mrs. ALBERT A. ROSENBERG, Atlanta, announce the birth of a son, Robert David, on the 21st of May. Mrs. Rosenberg is the former Miss Betty Beck, of Bessemer, Alabama.

Sixth District

Mr. Walter C. Dowling, a son-in-law of C. S. JERNIGAN, Sparta, Georgia's "GP of the Year," has been named ambassador to Korea. Mr. and Mrs. Dowling, the former Miss Alice Jernigan, have been in Bonn, Germany, for the past few years and before that he served as assistant ambassador to several other foreign countries.

WALTER J. REVELL, Louisville, has been appointed to the Jefferson County Board of Health filling the vacancy left by the death of J. J. PILCHER, Wrens, who served as a member of the Board of Health for many years. Dr. Revell is a native of Jefferson County and has been practicing in Louisville since the World War II. He is a graduate of Louisville Academy, the University of Georgia, and the University of Maryland College of Medicine.

On June 24, 1956, Miss Carolyn Frances Fowler of Milledgeville was married to JACK WALTER SMITH, Milledgeville. Dr. Smith is a graduate of Bremen High School, Emory University and the Medical College of Georgia. He is now a staff physician at the Milledgeville State Hospital.

Seventh District

Hugh S. Geiger, Jr., East Point, is now associated with CLAUD P. COBB, JR., East Point, in the general practice of medicine. Offices are located at 101 South Church Street, East Point. Dr. Geiger is a native of Florida and a graduate of the University of Florida and Emory University School of Medicine. He interned at Fitzsimmons Army Hospital and has had post graduate training in psychiatry at Fitzsimmons and Walter Reed Army Hospital. Prior to coming to East Point, he was engaged in the practice of general medicine in Iowa.

WARREN B. MATTHEWS, Marietta, led a panel discussion on "Is State Licensing of Medical Technologists Desirable?" at the recent meeting of the Georgia Society of Medical Technologists at the General Oglethorpe Hotel.

JACK M. WALDREP, Rome, announces the removal of his office to 309 West 7th Street, Rome, with practice limited to urology.

Eighth District

W. D. MIXSON, Waycross, retired eye, ear and nose specialist, celebrated his 86th birthday on April 18, 1956. Prior to his retirement several years ago, Dr. Mixson had practiced in Waycross for 39 years; and before coming to Waycross he had practiced in his native Alabama. He is a former president of the Ware County Medical Society and has been a Life Member of the MAG since 1944.

Ninth District

Doctors of the Ninth District have contributed over \$1,000 for the building of a medical center at Rainey Mountain Reservation for the Boy Scouts.

Tenth District

ROBERT B. GREENBLATT, Augusta, was one of the guest speakers at the annual spring meeting of the Georgia Dietetic Association in Augusta in May. His topic was "The Fat and the Lean."

JAMES J. McDONALD, Athens, was the speaker for the Athens Life Underwriters at their April meeting. Dr. McDonald talked on the subject of "Cancer" and illustrated his talk with color slides.

G. LOMBARD KELLY, Augusta, spoke at a recent meeting of the Augusta Lions Club on "The Organization of the Physical Properties of the Talmadge Memorial Hospital." Dr. Kelly has announced that after July 2, 1956, his office will be located at 211 Grand Theatre Building in Atlanta, with practice limited to the field of sexual science.

EDGAR R. PUND, Augusta, recently addressed the Laymen's League of the Church of the Good Shepherd.

VIRGIL P. SYDENSTRICKER, Augusta, has been appointed dean of postgraduate medical education and professor of medicine at the Medical College of Georgia. Dr. Sydenstricker, the senior faculty member of the Medical College of Georgia, has been a member of the faculty since 1919, and has been professor of medicine since 1922. He succeeds RUFUS PAYNE in the office of dean of postgraduate medical education. Dr. Payne will from now on devote his full time to the office of superintendent of the Eugene Talmadge Memorial Hospital.

RICHARD TORPIN, Augusta, addressed the members assembled of the Georgia State Medical Association of Physicians and Pharmacists on "Toxemias of Pregnancy" when that association met in Augusta in May. At this same meeting, WILLIAM H. MORETZ, Augusta, spoke on "Management of Head Injuries," and HARRY P. O'REAR, Augusta, spoke on "Diagnosis and Treatment of Common Pediatric Infections." All three physicians are members of the faculty of the Medical College of Georgia.

CLAUDE-STARR WRIGHT, Augusta, was a participant in the panel discussion on "The Newer Aspects of Blood Dyscrasias" at the Annual Meeting of the South Carolina Medical Association held in Myrtle Beach, S. C., on May 15, 16, and 17, 1956. Dr. Wright is associate professor of internal medicine at the Medical College of Georgia.

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Journal OF THE MEDICAL ASSOCIATION OF GEORGIA

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COVER

CREATION—BY TED F. LEIGH, M.D. We trust you have noted that the space ships are the eye and its muscles, and the planets are fundi.

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Due to a conflict with Easter Sunday

The *103rd Annual Session

of the Medical Association of Georgia

has been changed to **April 28-May 1, 1957**

DeSoto Hotel, Savannah

the executive secretary's letter

WHILE THE DAY-BY-DAY routine of the Association Headquarters Office is familiar to the MAG officers and committee chairmen, the membership at large has little knowledge of the specific activities that come under the broad term of the "administrative function" performed by this office. If members are to take full advantage of these office facilities designed to serve them, a brief examination of the Headquarters Office is in order. To this end, a single day in the executive secretary's slot will best illustrate the function of your state medical association's central office.

8:40 a.m.

Checked with the two office secretaries on work in progress. Discussed the new revised "Georgia Plan" mailing to all members aimed to stimulate physician participation in this voluntary surgical insurance plan which was designed by the MAG Insurance and Economics Committee and is now being offered to the public.

9:15 a.m.

Conferred with the assistant executive secretary on the replies from an extensive questionnaire sent 959 physicians seeking data for the "Hospital Care Study Commission" which was created by the Georgia General Assembly; as a result of 1955 MAG House of Delegates action, to study the problems of hospital care for the indigent of Georgia. Also discussed activity of the State Medical Education Board, a state agency created to provide medical school scholarships for students intending to practice in sparsely settled rural areas of Georgia, which pointed up need for closer liaison in effective physician placement. The Better Health Council of Georgia and the MAG

are trying to aid this board in ascertaining the "best" locations for new doctors.

9:35 a.m.

Read morning mail. Routinely dictated answers to queries and referred county medical society secretaries' membership reports to the membership and bookkeeping secretary. These reports pointed up the need for further clarification of the MAG membership categories as revised by 1956 House of Delegates in the MAG *By-Laws*. Although a membership classification chart was sent each society secretary, the membership at large is unfamiliar with the new categories, rights and privileges. Asked the assistant executive secretary to discuss this on field trips to county society meetings.

Requested that copies of the 1956 revised *Constitution and By-Laws* (as published in July 1956 *Journal*) be mailed to all county medical society presidents and secretaries with covering letter to stimulate county societies to revise their constitutions and by-laws to conform to MAG.

10:40 a.m.

Phoned, in behalf of Medical Education Subcommittee on Liaison with Emory University School of Medicine, appointees of the dean of the medical school and the president of Medical School Alumni Association. This committee will meet at least twice annually to further medical education and discuss associated problems. The subcommittee is composed of a member of MAG Medical Education Committee, a member appointed by the dean of the medical school, and a member appointed by the president of the Medical Alumni Association. The subcommittee was formed on recommendation of the AMA, and a

similar subcommittee is set up with the Medical College of Georgia.

11:00 a.m.

Left office to attend a preliminary meeting with representatives of other agencies interested in forming a statewide group to act on automobile safety. MAG Public Service Committee considers this one of its top projects for 1956-57. MAG facilities and extent of cooperation were outlined, and it was agreed that the MAG Public Service Committee chairman would serve for the Association with other groups in designing and implementing a statewide program for increased auto-safety.

12:30 p.m.

Met for lunch with MAG Secretary to clarify MAG policy on certain medical problems. Discussed AMA meeting on P.L. 569, Medical Care for Military Dependents, at which MAG Secretary represented Association. Public Law 569 provides for the insurance of civilian medical care for dependents of members of the uniformed services. The program generally provides a full range of hospital and medical services, except for out-patient care. AMA consulted state medical association representatives on some of the problems inherent in the implementation of this law.

1:35 p.m.

Prepared 1957 Annual Session "fill-in" forms to be mimeographed for use at the first meeting of the 17 specialty society program chairmen. These chairmen, lectured and representing their own specialty societies, design and makeup the section meetings of the Association's annual session. Although the actual Annual Session date, April 28 - May 1, 1957, DeSoto Hotel, Savannah, is some nine months off, the scientific program must be arranged during the summer and early fall. The overall physical set-up of the program is arranged by the Annual Session Committee of Council in cooperation with the host county medical society. Specialty society chairmen get together and form joint section meetings, arrange for their society luncheons and dinners (which are not a part of the official program), and in this manner compose a scientific program of interest to every member.

2:15 p.m.

Received a phone call from a physician covered under the Association—St. Paul Mercury Professional Liability Program. Physician reported the possibility of a claim's being brought against him concerning medical care given a patient. Made an appointment with the physician to get the data on this

matter and phoned the St. Paul Insurance adjustor to request that he accompany me to interview the doctor. In this way, the data will be complete and will be filed. Should an actual claim be filed against the physician, all the data secured will be available, and the doctor, his county medical society professional liability committee, the adjustor, and the attorney will meet to ascertain if the case is defensible in court. Experience has shown this "team" approach to professional liability problems to be most effective in protecting medical integrity.

2:40 p.m.

Conferred with the chairman of the Council Committee on Headquarters Office Building. As a result of 1956 House of Delegates action, a committee was activated to study and investigate need, size, possible location, and financial undertaking of an Association headquarters office building.

3:30 p.m.

Dictated for a rough draft the minutes of the last meeting of the MAG Council. It is the policy of the Headquarters Office to mail within one week minutes of any meeting to members participating in said meeting. A rough draft of minutes is provided the MAG secretary so that he may make additions, deletions, and corrections, as meeting minutes are the responsibility of the secretary. These minutes are then mimeographed and mailed and are also published in the *Journal*.

4:10 p.m.

Rechecked on secretarial work in progress. Checked study in progress on all maternal deaths (obstetric and non-obstetric) being done in cooperation with the State Department of Public Health at request of MAG Maternal and Infant Welfare Committee.

4:30 p.m.

Attended meeting of the Liaison Committee to Study Revision of the Medical Practice Act. The MAG and Medical Examining Board have representatives on this committee whose main problems are to strengthen the injunction and revocation section of the Medical Practice Act and further investigate the problem of temporary license; i.e.: foreign medical graduates seeking some type of licensure. Minutes of meeting to be forwarded Medical Examining Board for their consideration.

And so it goes—another day with six lay persons employed by the MAG, functioning in an administrative capacity in behalf of the physicians of Georgia.

Intramuscular Trypsin in the Treatment of Acute Thrombophlebitis

WILLIAM A. REID, M.D., and ALBERT H. WILKINSON, JR., M.D., Atlanta, Ga.

ACUTE THROMBOPHLEBITIS, followed not infrequently by the post phlebitic syndrome, has been an unsolved therapeutic problem. The host of therapeutic agents employed in its management evidence their partial failure. Antibiotics, ambulation of the post-operative patient, lumbar sympathetic block, and the extensive use of anticoagulants have provided only limited adjuncts to therapy.

Clinical Data

Since the combination of bed rest, elevation, anticoagulants, and antibiotics is among the most widely accepted therapeutic measures for thrombophlebitis, a series of patients with thrombophlebitis treated by this means was selected as a control group. The study group of patients received the same regimen except that intramuscular trypsin was employed in lieu of anticoagulants. In order to avoid selectivity, alternate patients were arbitrarily given one drug or the other. All patients in the clinics and the wards of Grady Memorial Hospital between October 1, 1954, and August 15, 1955, in whom the diagnosis of acute thrombophlebitis was made were seen by the authors.

In some instances, the acute attack represented the initial episode of the disease, while in others, it was an acute exacerbation of the relapsing syndrome. All degrees of severity were included, and for purposes of classification they were grouped as mild, moderate, and severe. (Table I)

The clinical criteria employed in evaluating each patient involved an arbitrary evaluation of each of the following: resting calf pain, pain on dorsiflexion, edema, heat, erythema, fever, tachycardia, and progression of the thrombosis. Each criterion could not

be evaluated in every patient, for in certain patients concomitant complications made tachycardia or fever unreliable as reflections of the course of thrombophlebitis.

Patients who displayed accompanying cellulitis, infected leg ulcers, or acute arthritis in an extremity were excluded from the study because of the clinical difficulty in evaluating thrombophlebitis under these conditions.

Since previous studies by other investigators¹ have demonstrated that parenteral trypsin in the small dosage used in this series has no effect on blood coagulation factors other than a slight lowering of the prothrombin time, these factors were not restudied.

In both the control and study groups, penicillin and streptomycin were used throughout the febrile period. The combination of these drugs was selected to omit a possible variable in the study because of the frequency of use of penicillin and streptomycin in post-operative patients.

All patients were placed on strict bed rest. Neither heat nor compression bandages were utilized. Anal-

Severity of Clinical Features	Number of Patients	
	Anticoagulant Group	Trypsin Group
1. Mild	16	17
2. Moderate	7	4
3. Severe	7	9
Total:	30	30

Table I
Severity of Thrombophlebitis in Control and Study Groups

From the Whitehead Department of Surgery, Emory University, and The Grady Memorial Hospital, Atlanta, Georgia.

gesics were not used because of difficulty in evaluating clinical criteria.

In the control group, initial treatment consisted of intravenous heparin usually in dosages of 50 mg. I. V. every four hours. An initial prothrombin level was obtained. If this were within normal limits, the dosage of 300 mg. of dicumarol initially followed by 200 and 100 mg. on consecutive days was used. Prothrombin activity was determined daily, an attempt being made to maintain the level between 20 and 30 per cent of normal. Heparin was discontinued as soon as dicumarol had produced this therapeutic level.

Patients in the study group received 2.5 mg. (0.5 ml.) of trypsin* deep intramuscularly in alternating gluteal regions every eight hours. Since contact with water diminishes activity of this drug, thoroughly dry syringes were used for its administration.

All patients were evaluated daily. In both the control and study groups the drugs were discontinued as soon as the patient became asymptomatic. The next day the patient became ambulatory, and if symptoms did not recur the patient was discharged on the third day of observation. In the event that symptoms recurred with ambulation, therapy was restarted.

The age groups studied varied from three months to 85 years with an average of 43.7 years. There were 27 males and 33 females in the series distributed among 19 white and 41 Negro patients. No conclusion could be drawn from the temperature and pulse curves because of associated diseases.

Discussion

The general clinical response in patients receiving trypsin was comparable to or even better in some respects than those receiving anticoagulant therapy. (Table II) The average number of days elapsing before the patient became asymptomatic was 1.3 shorter in the intramuscular trypsin group. The time required for patients to become pain free was also less in the group treated with intramuscular trypsin.

Local toxic effects, pain, and induration, as noted in a total of 867 injections, were minimal and never necessitated discontinuance of the drug. This probably resulted from the careful administration of the drug, deep in the gluteal muscle. The deltoid muscles were never used. No generalized toxic reactions nor post-operative complications such as impairment of wound healing or hemorrhage were noted to suggest the possibility of afibrinogenemia as was found by Roach² with intravenous trypsin.

Although the precise action of small doses of intramuscular trypsin on the blood clotting mechanism of the body is unknown, previous reports suggested that intravenous trypsin probably activates one of the en-

* Intramuscular trypsin (Parenzyme) supplied by the National Drug Company.

	Days Anticoagulant Group	Trypsin Group
1. Average time before significant improvement in pain.	3.8	4.0
2. Average time before complete relief of pain.	9.4	7.4
3. Average time before asymptomatic.	9.9	8.6
4. Average time before local fever subsided.	5.7	5.4
5. Average time before significant improvement in swelling.	3.8	4.0
6. Average time before improvement in Homan's sign.	3.2	4.0
7. Average time before negative Homan's sign.	4.3	5.3
8. Average period of hospitalization.**	14.7	10.8
** Represents duration of hospitalization necessitated by thrombophlebitis.		

Table II
Incidence in Control and Study Groups of Principal
Clinical Criteria for Evaluating Thrombophlebitis

zymatic systems. Innerfield¹ suggested that an efficient fibrinolytic system is essential for trypsin to act and that trypsin can only activate such a system. Lewis⁹ found that profibrinolysin in the dog is completely converted to fibrinolysin by intravenous trypsin. Available methods of study demonstrate no significant changes in the clotting mechanism other than a minimal decrease in the prothrombin activity.

It was necessary to discontinue anticoagulant therapy in five of the 30 patients treated with heparin and dicumarol. Two of these patients had hematuria, one patient had epistaxis, another patient had bleeding from a post-operative colpotomy, and the last patient had bleeding from a carcinoma of the transverse colon.

In this series of 60 patients, two patients experienced non-fatal pulmonary infarctions. One of the patients developed mild acute thrombophlebitis two days post-operatively. Intramuscular trypsin was instituted at that time and was continued for nine days. On the ninth day of treatment, which was the day of ambulation, the patient had a sudden onset of left anterior chest pain with dyspnea, a transient drop in blood pressure, and moist rales bilaterally. The electrocardiogram and roentgenograms of the chest revealed no definite evidence of pulmonary infarction. Trypsin therapy was discontinued in order to

TO REACH MORE AND MORE American people with authentic up-to-date health information, the AMA's Bureau of Health Education announces several major plans for 1956. A series of articles on a broad range of health subjects are being compiled from *Today's Health* magazine over the past two years for reprinting in a volume entitled, *The AMA Book of Health*. The Dell Publishing Co. plans to issue this material in a 35-cent edition for sale in approximately 100,000 outlets such as railroad and bus stations and drugstores.

Also published in book form is the series of five sex education booklets prepared by the Joint Committee on Health Problems in Education of the AMA and the National Education Association. Each of the five books is slanted at a different age group, from parents of young children to grade schoolers, teenagers, young people, and adults having the responsibility of children (teachers or youth counselors). Response to the AMA-NEA editions of the series have been overwhelming, and to date the AMA has sold more than 100,000 copies.

Intramuscular Trypsin . . . (continued)

permit institution of anticoagulant therapy. Three days after dicumarol and heparin had been instituted, the venous tenderness which had previously disappeared on trypsin therapy returned. Nine days later it was necessary to discontinue dicumarol because of moderate epistaxis. The patient fully recovered from her disease and was discharged without further difficulty.

The second patient with a pulmonary infarction was a 24 year old colored woman who was in the sixth day post partum, having been admitted for acute thrombophlebitis. After 72 hours of intramuscular trypsin she developed a moderate degree of dyspnea, tachycardia, and hemoptysis. Her blood pressure dropped from 126/82 to 94/60. It was felt that this patient had clinical evidence of a pulmonary infarct, and intramuscular trypsin was discontinued. The chest film and the electrocardiogram were normal. Following a prolonged hospital stay, she was discharged with residual edema in one lower extremity, indicative of the post-thrombophlebitic syndrome. Thirty days later she was readmitted for recurrent thrombophlebitis. After treatment with anticoagulants, she was discharged and has had no further difficulty.

Summary

1. A study of intramuscular trypsin in the treatment of thrombophlebitis as compared with a controlled series treated with anticoagulants is presented. Sixty patients were included.
2. No significant local pain, swelling, or induration was noted in this study of 867 intramuscular injections of trypsin.
3. The group treated with intramuscular trypsin became pain free two patient days less than the anticoagulant group, asymptomatic 1.3 days less than the anticoagulant group, and the total number of hospital days was 3.9 less in the intramuscular trypsin group.
4. Five patients in the anticoagulant group re-

quired discontinuation of the drug because of bleeding.

5. Clinical evidence of non-fatal pulmonary infarction occurred in two patients treated with intramuscular trypsin.

6. Neither abnormal bleeding nor impairment of wound healing was noted in the immediate post-operative patients treated with intramuscular trypsin.

7. Continued study is essential to the proper evaluation of the effectiveness of intramuscular trypsin therapy in thrombophlebitis.

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Mechanisms and Management of Spontaneous Pneumothorax

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APPROXIMATELY ONE in every thousand patients admitted to hospitals in the United States has a diagnosis of spontaneous pneumothorax. In the past 20 years the literature has been flooded with reports of cases, and yet the majority of them has not been accounted for in medical literature. These cases are treated by physicians in all branches of medicine, and it is distressing that there has been no general agreement as to the treatment of this condition. It is our purpose to present a series of 139 cases treated in the Atlanta area during the past five years and to present what we believe is a rational approach to the plan of treatment.

The term pneumothorax was first employed in 1802 by Itard, when he reported five cases diagnosed at autopsy. As early as 1776 the possibility of this condition has been postulated, however. Laennec is credited with having suspected the role played by emphysematous blebs in the production of pneumothorax. The first instance in an apparently healthy individual was described by McDowell in 1856. As most of the reports in the literature of this period were from tuberculosis institutions, tuberculosis became the accepted etiology of the condition. In 1932 cases began to appear in medical journals in persons not victims of tuberculosis, and now we know that it is rarely a direct cause of pneumothorax.

It has been difficult to establish the exact pathogenesis of spontaneous pneumothorax because of the low mortality. Rich and Rapport have classified the suspected etiologic factors as follows:

- I. Structural cystic lung changes, including congenital lung cysts, cystic bronchiectasis, hypertrophic or chronic, obstructive emphysema, and blebs formed as the result of a chronic specific or nonspecific inflammatory process.
- II. Pulmonary tuberculosis. Here a rupture of a caseous focus on the pleura or occasionally pneumoperitoneum is complicated by pneumothorax.

III. Trauma. Traumatic spontaneous pneumothorax implies an indirect mechanism consisting of a sudden increase in the intra-bronchial pressure which produces a rupture of the intervening tissues into the pleural space.

IV. Idiopathic. It must be admitted that in many cases we are unaware of the exact etiology.

In 1915 Hagashi and Fisher reported the discovery of bronchial scarring which produced a check-valve allowing the passage of air in only one direction. This resulted in building up intra-alveolar pressure so as to form a bleb. Bronchospasm, mucosal edema, neoplasms of the lung, and acute infections may produce a similar type of respiratory obstruction. Miller states, "Bullae are produced by the ruptured of the elastic fibers of subpleural alveoli into the areolar layer of the visceral pleura." In most cases where the bleb ruptures the walls seal the fistula, and the lung expands uneventfully. In some instances, however, guy-wire intrapleural adhesions, fibrosis from pleural disease, a pleural membrane, or persistence of the check-valve mechanism maintains a continuous or intermittent fistula which keeps the lung collapsed and may build up great tension within the pleural space.

Macklin and Macklin have described a mechanism of alveolar rupture followed by dissection of the air into the connective tissue so as to produce an interstitial emphysema. The air dissects along the perivascular spaces and may enter the mediastinum or may pass through a weak point in the visceral pleura to produce pneumothorax.

Dr. Skandalakis has performed six simple experiments in an effort to determine the magnitude of intrabronchial pressure necessary to cause a break in the visceral pleura. The method was to place a constricting clamp across the upper trachea of a fresh cadaver and then to insert a small needle into the trachea distal to the clamp. The needle was connected by means of a Y tube to an oxygen tank and an aneroid manometer. The oxygen was released into the system and the pressure gradually increased until the lung ruptured. The indication of rupture in the

Presented at the 105th Annual Session of the Medical Association of Georgia, Augusta, May 1-4, 1956.

latter group was the escape of air from a closed thoracotomy tube inserted prior to the application of pressure. In the open chest the value ranged from 110-170 mm. hg., and with the chest intact from 150-210 mm. hg. Each lung used showed either emphysema or passive congestion on pathologic examination. These experiments were done under conditions which admittedly allow error, but they give a rough idea of the pressure necessary to produce pneumothorax. Normal breathing, even though done quite vigorously, does not increase the intrabronchial pressure above 100 mm. hg. according to Howell. So some mechanism, such as a check-valve, would seem necessary to allow building up sufficient tension to cause a rupture.

There has been considerable speculation as to the manner in which pneumoperitoneum leads to pneumothorax. One idea supposed that prolonged tension on the diaphragm leads to thinning and eventual rupture. Also passage of air through congenital defects has been demonstrated. The differential pressure between the thorax and the abdomen has also been blamed.

The symptoms of pneumothorax are well known. Most frequently a sharp chest pain initiates the pattern, followed by dyspnea, weakness, and perhaps sweating. Usually these subside after a few hours. The physical findings vary with the degree of collapse and may be absent. X-ray is the most valuable diagnostic aid. Expiratory films exaggerate the air space and facilitate the discovery of slight degrees of collapse. It is very difficult to estimate the degree of collapse. Kircher has demonstrated a method by which fairly accurate determination can be made. Two similar rectangles are constructed representing the lung and hemithoracic areas respectively. The ratio of the areas of the rectangles gives the approximate percentage of collapse.

One hundred and thirty-nine cases have been studied for presentation. The findings are not different from those of other authors in most respects. The results are difficult to evaluate in a series of cases such as this. Most patients are lost to follow-up. At least symptomatically all results were good except where complications are listed. Two cases of hydrothorax were infected and one failed to stop bleeding. There were four deaths. Three of the four deaths resulted from failure to treat the condition present.*

In October 1954, this statement appeared in the literature: "Aspiration of air either by needle or catheter is neither indicated nor advisable. The creation of abnormal negative pressure in the pleural cavity may keep the pleural rent open." The authors

* Since the original writing of this paper two additional cases with serious hemorrhage have been encountered, both due to failure to release tension promptly. Both were successfully treated without thoracotomy.

feel that no single method can be used for all patients with pneumothorax. The treatment must fit the severity of the collapse and other factors which can vary greatly. Kircher estimated that pneumothorax will absorb about 1.25 per cent per day without active therapy. So it is medically and economically sound to treat cases of 10-15 per cent collapse by conservative measures. Certainly with collapse above 30 to 50 per cent, efforts to speed the re-expansion of the lung should be considered. Aspiration with a needle may be tried. If collapse recurs, the insertion of a small catheter to enable the use of water seal drainage is indicated. In most instances, expansion is immediate, and the tube can be removed within 48 to 72 hours. Slight fever and some discomfort are associated with closed thoracotomy, but in our experience there has been no empyema when it was possible to remove the catheter within one week. Antibiotics are used while the tube is in the chest.

If the fistula has not closed within 48 hours, suction of minus 10 to minus 20 cm. water is applied. If this is unsuccessful, bronchoscopy is next employed. In several of our cases, a segmental atelectasis apparently was causing the rent in the pleura to remain open, and prompt closure followed relief from the atelectasis.

Certain cases require open thoracotomy. In our series there were 12 open thoracotomies. Eight were for recurrent pneumothorax, two for persistent pleural fistula, one because of uncontrolled hemorrhage, and finally one thoracotomy was done for cardiac arrest on the operating table. The surgical treatment of the lung in all cases was the removal or infolding of blebs and bullae, followed by talc poudrage or simply scrubbing the pleura with a sponge to promote pleural synthesis. There were no complications or mortalities from surgery except for the patient with cardiac arrest.

Many agents have been tried in the pleura, prior to operation, in an effort to cause adhesions. Because of the observation of dense adhesive pleuritis in patients following treatment by local instillation of nitrogen mustard into the pleural space for effusions, this method is being tried in a few recurrent cases. So far the results seem promising, but a conclusive series has not been run yet. The side effects are mild, but there has been no complication to date.

Summary

A brief resume of the history of the treatment of spontaneous pneumothorax has been presented along with a discussion of the possible etiologic factors and mechanism of production.

One hundred thirty-nine hitherto unreported cases are presented.

The authors' methods of treatment are discussed,

Past History	No. of Patients
No pulmonary past history	61
Tuberculosis	8
Asthma	13
Emphysema	21
Bronchiectasis	8
Previous pneumothorax	21
L. T.	5
Pneumonia	1
Stab Wound	1

Table I

Age Distribution		No. of Patients
Years		
0-1		3
2-10		2
11-20		5
21-30		64
31-40		36
41-50		4
51-60		14
61-70		9
71-80		2
Sex Distribution		
Male	Female	
120	19	
Lung Involved		
Left	Right	
75	64	

Table II

Abnormal Acts	No. of Patients
No abnormal acts	117
Bending over	3
Strangled drinking coffee	1
Auto acc'd. (no blow rec'd.)	1
Digging ditch	1
Loosening ice tray	1
Fishing	1
Paroxysm coughing	1
Unspecified abnormal act	1

Table III

Time Before Admission	No. of Patients	Mean Temp.
Hours		
0-2	5	97.8°
2-12	48	94.4°
12-24	28	98.4°
24-48	6	99.8°
Days		
2-3	20	99.4°
4-7	8	96.6°
7-14	10	98.4°
Longer	14	98.6°

Table IV

Symptom	No. of Patients
Fever	
Present	30
Absent	109
Mediastinal Emphysema	
Present	24
Absent	115
Subcutaneous Emphysema	
Present	26
Absent	113
Pain	
Severe	35
Mild	69
None	35
Dyspnea	
Severe	33
Mild	54
None	48
Cough	
Present	47
Absent	92
Cyanosis	
Present	11
Absent	128

Table V

Treatment	Mean Per Cent Collapse	Mean Hospital Days
Bed Rest Only		
45 cases	52%	8
Aspiration Only	55%	10
Closed Thoracotomy		
50 cases	74%	17
Open Thoracotomy with Repair of Defect		
12 cases	76%	16

Table VI

Complications of Treatment	No. of Patients
1. Recurrence of Pneumothorax	3
2. Hydrothorax	34
3. Empyema	2
4. Hemothorax	2

Table VII

MORTALITY (4 Cases, 2.9%)		
Diagnosis	Age	No. of Patients
Undiagnosed during surgery, Cardiac arrest	78	1
Undiagnosed, untreated	61	1
Died in coma, apparently respiratory failure	62	1
Died of hemorrhage	33	1

Table VIII

Federal Grants Increased for Research

IF MEDICAL RESEARCH doesn't move ahead in the current fiscal year (ending June 30, 1957), it won't be the fault of Congress. The seven research organizations that make up the National Institutes of Health have far more money than they have ever had, and probably much more than their directors even dared hope for last winter at the start of hearings on their budgets. Every one of the research institutes received a substantial increase over last year, and the funds of five of them were almost doubled.

The Institutes have a total of \$170.4 million to spend before next July 1. This is about 80% more than they had last year. In discussing the appropriations bill on the Senate floor, Senator Lister Hill (D., Ala.) said the bulk of the money will go for grants to non-federal institutions—hospitals, medical schools, clinics and state and local organizations engaged in research.

A breakdown by disease categories shows the following picture:

For cancer research, \$48.4 million, in contrast to \$24.8 million for the previous year. This year's total is \$16 million more than the administration asked when budget requests were sent to Congress in January.

For mental health work, \$35.1 million, in contrast to last year's \$18 million. This is \$13.4 million more than had been requested originally.

For heart disease research, \$33.3 million, compared with \$18.7 million last year and \$22.1 million originally requested.

For work on arthritis and metabolic diseases, \$15.8 million, or \$5.1 million more than last year and \$2.5 million more than Congress was asked for.

For research in neurology and blindness, \$18.6

million, compared with \$9.8 million last year and \$12.1 million originally requested.

For work on allergies and infectious diseases, \$13.2 million, compared with \$7.5 million last year and \$9.7 requested.

For dental research, \$6. million. While this is small compared with money voted for other U. S. research institutes, it is almost triple the \$2.1 million spent last year. The huge increase is the result of a sustained campaign by the American Dental Association.

POLITICS IS YOUR BUSINESS

AMERICAN DOCTORS SHOULD take a more active role in politics, says Rep. Walter Judd (R., Minn.), himself a physician. Many physicians work such long hours and pay such close attention to their patients, he says, that they sometimes fail "to take the longer view . . . They won't get into politics; they won't discuss issues with their patients; they won't even bother to vote; they just go ahead and work. They're good in their profession. But what makes them good specialists sometimes makes them poor citizens."

The Congressman's opinions of his former colleagues appeared in a recent issue of *Medical Economics*. He finds evidence for his views in the small amount of mail he receives from physicians on non-medical issues.

"Doctors seem to concentrate on their own interests more than most groups," he comments. "I don't say this critically; it occurs as a result of their specialization. But we get less mail from doctors on general issues—international policies, farm policies, education, etc.—than from practically any other group in our population."

... Spontaneous Pneumothorax (continued)

and stress is placed on individualization of treatment according to the type of problem presented.

The prognosis of simple, uncomplicated pneumothorax is good, and few complications are to be expected.

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Psychological Implications of Surgery

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THE PSYCHOLOGICAL reactions to surgery are many and varied. A few systematic investigations have been made to determine some of the etiological factors of these reactions. An effort has also been made to predict prior to operation the patients that are most likely to develop major psychiatric disorders as a result of surgery. In this paper I will review some of the literature as to etiological factors and point out some of the reactions that frequently follow specific types of operative procedures.

Some investigators feel that the operation itself is an important factor but point out that the importance of this depends largely upon the premorbid personality. Reactions are also determined by preoperative conditions, anesthetic, other drugs used in conjunction with the anesthesia, organic factors resulting in endocrine upsets, and the presence of vascular disease.

"Toxic delirium," or acute brain syndrome, is a rather frequent complication of surgery, and it is felt by most people to be due to a combination of things such as anesthetic, other drugs used prior to and after the operation, and so-called toxins. The symptoms of this syndrome are usually confusion, hallucinations, especially visual, a defect in memory and orientation, and hyperactivity. These symptoms are usually of fairly short duration and can be controlled best by the use of reserpine. We have had very good results with reserpine in the control of this syndrome where the cause was alcohol or drug intoxication. Usually the symptoms clear up within 24 hours if adequate doses of reserpine are used. It has been reported recently by Fabing¹ that even a newer drug by the name of frenquel gives better results than reserpine. I will confine the rest of this paper to other types of emotional illnesses that follow surgery.

Onset of Emotional Illness

It may be interesting to mention time of onset of major emotional illnesses following surgery. Washburne and Carns² found that a great percentage of psychotic reactions following surgery occurred between the third and fifth day postoperatively. This observation was also confirmed by Abeles³. Some of

the findings of Burger and Grauhan⁴ are extremely interesting in that they found that there was a 200 per cent increase in the Nitrogen excretion over the postoperative period. The highest occurred two or three days after the operation. They also found that the anti-trypsin titer increased and was highest on the fourth to the fifth day. Trypsin is produced at the operative incision in order to break down and help in the assimilation of protein products. What makes this so interesting is the fact that recent research stimulated by some of the newer drugs, reserpine and chlorpromazine, indicates that tryptamine probably at least precipitates some of the major symptomatic psychoses.

Incidence of Postoperative Psychoses

Rohe⁵ of Baltimore analyzed 196 cases of postoperative psychoses and found 65 of these cases followed genital operations and 35 followed cataract operations. He also found that incidence of postoperative psychosis in this series was four times greater in the female. However, Sears⁶ showed some time later that in comparable operations the percentage of women and men were equal. Lindemann⁷ found in a group of 40 surgical patients that 40 per cent of the patients who had pelvic operations developed serious emotional disorders postoperatively. His patients either had pelvic or abdominal surgery. They were studied prior to their surgery, and none had any evidence of serious emotional illness at this time. Any case that was complicated by a somatic disorder following surgery or developed a toxic delirium was eliminated from his series. The symptoms usually came on from three to four weeks postoperatively. They usually consisted of anxiety, mild agitation, and a pre-occupation with depressive thoughts. Some of these cleared up rather shortly, but others went on to more serious illness necessitating long-term hospitalization.

In this series of 40 patients, they were not only interviewed preoperatively but were also seen six months to a year after the operation. An attempt was made to find out if by preoperative examination they could predict what patients were most likely to develop a major emotional illness. In 25 patients the postoperative findings showed there had been no

Presented at the joint meeting of the Southeastern Society of Neurology and Psychiatry and the Georgia Medical Society, October 11, 1955.

change at all in their emotional makeup. Two patients reported marked relief of former psychiatric symptoms. Thirteen of the 40 who had no preoperative psychiatric symptoms developed a syndrome resembling agitated depression. In the 25 mentioned, it was predicted that eight of these would show symptoms after operation. The predictions, based upon the presence of anxiety and upon the history of emotional strain or symptoms of emotional instability, turned out to be correct in only eight of the 13 patients who developed depressive syndromes. It is obvious that their predictions were not very accurate. They felt that the most definite indication for the possible appearance of postoperative symptoms was a history of previous depression in a person who had to undergo pelvic surgery. Recently a white, married, female patient in our hospital gave a history of having had pelvic surgery three months prior to admission. This consisted of the removal of part of one ovary and one tube. Three weeks after the operation she became mildly depressed, showed some signs of depersonalization, and entertained suicidal ideas. She states: "The operations seemed to take my emotions and feelings away from me, and it took everything out of me." This case would fit very well into the syndrome just described above.

Psychiatry as an Aid to Surgeons

In 1943, Blanton and Kirk⁸, of Vanderbilt University Medical School, undertook a study in an effort to discover clinically how the emotions enter into the etiology, treatment, and convalescence of surgical patients and to determine if and how psychiatry could be of some aid to the surgeon. This study was based on examination of 61 consecutive admissions of patients operated on for appendicitis. The patients were all white men and women ranging between the ages of 16 and 55. When it was possible, preoperative interviews and psychological studies were made. If signs of anxiety were present, an attempt was made to relieve this prior to operation. In most cases very little was learned about the patients until after the operative procedure. Systematic psychological studies were started approximately 12 hours after the operation. These consisted of Wechsler-Bellvue and Stanford-Binet intelligence tests, family and personal history, and at times a Rorschach examination was used. After these tests were evaluated, routine interviews were started and usually lasted for a period of several weeks. An attempt was made to find out from the surgeon the patient's physical and emotional attitudes. It was felt that these studies provided a basis for coming to grips with the problem of anxiety associated with operative procedures.

These 61 patients were classified or rated as to their degrees of anxiety, and the ratings were *a*, *b*, *c*,

d, and *e*. In the first three groups, *a*, *b*, and *c*, were the patients who had varying degrees of anxiety, but most of it was concerning the operation itself and was not considered to be of a neurotic degree. In the fourth group, *d*, are the patients who reacted with an hysterical pattern. Such people often showed marked anxiety and fear. In this group fell many of the well-known surgical cases where physical symptoms were produced directly by emotional conflict. Eighteen per cent fell into this group. In the *e* group were patients who reacted with marked anxiety and had a definite anxiety neurosis of long standing. Many of these patients were made worse by the experience of surgery. Thirty-one per cent fell into this group. The actual physical illnesses of these patients were classified into two groups. Group I included the cases of acute appendicitis and cases of abdominal disease sufficiently serious to cause an appendicitis-like pain, such as ileitis or ruptured graafian follicle. Group II consisted of cases of so-called recurrent chronic appendicitis where no acute inflammation of the appendix was found and also where no pathology of related organs was found in the abdomen. It is quite significant that all the patients in Group II were in the *d* and *e* ratings of the original classification. Seventeen patients, or 28 per cent of the 61 fell into Group II.

It was noted by Blanton and Kirk⁸ that these studies could be of some help to surgeons and patients. They felt that it was essential that the patients who were found to be definitely neurotic should have psychiatric treatment, and this would prevent unnecessarily prolonged convalescence and reduce the number of patients having needless operations. They also pointed out that none of the patients objected to the extra attention that they received as a result of these studies, and most of them welcomed it.

Zwerling et al⁹ reported at the American Psychiatric Association Meeting in May 1955, on a systematic psychiatric study of 200 surgical patients. In this study no effort was made to select an experimental group that presented greater or lesser likelihood of emotional disorder than the average patient on the surgical service. This was a group of 200 selected from 3,671 patients admitted during that period of time. The patients were interviewed frequently while they were in the hospital for their surgery, and three months after discharge they were again interviewed by one of the psychiatrists participating in this study. Information was also obtained from relatives or friends through the Social Service Department.

It was felt that this group of patients contained a very high proportion of individuals presenting neurotic symptoms, disturbed behavior, or psychotic

signs. It was felt that surgical illness was more likely to befall the emotionally disturbed person. In a high percentage of the cases studied, emotional factors were closely associated in some way with the development of surgical illness. They found that many of the patients presented symptoms similar to common surgical complaints but which were actually physiologic concomitants of neurotic illness. No definite conclusions were arrived at by these investigators, but it was felt that more study along these lines was needed to determine a specific relationship between emotional factors and surgery.

General Reactions to Specific Types of Surgery

Weengraf¹⁰ reported on 32 neurotic patients who had undergone hysterectomy for fibroids. Only six of these 32 neurotics who had hysterectomies believed that their neuroses became more severe after the operation. It is interesting that he reports that many women who had hysterectomies were deserted by their husbands. When these patients were questioned about the reasons for desertion, they stated, "He had no use for half a woman." It was also noted that many neurotic manifestations occur in men after their wives have had gynecological operations, stating that the most common symptom to appear is impotence. It is accepted by most people that many patients who undergo hysterectomy frequently have the feeling of being castrated and that their entire femininity is threatened. Too frequently we generalize and apply this principle to all women who have such an operation. Shortly after admission to this hospital, one of our 41-year-old patients, who depressed and anxious, expressed many ideas that led us to believe that she probably had a decrease in her sexual drive following a hysterectomy 10 years before admission. After finding out more about this patient it was realized that patient actually had a marked increase in her sexual drive, beginning shortly after the hysterectomy. Recently we became interested in the reactions of women who had had surgical procedures, especially hysterectomies, and we are in the process of setting up a study to determine what the specific reaction of this large group of patients is. Of the 896 female patients admitted to this hospital since it opened in November 1951, 117 have had hysterectomies. I have been informed that this percentage of hysterectomies is much greater than in the average female patient.

Kroger and Freed¹¹ felt that patients having hysterectomies could be helped very much to understand that unattractiveness, premature senility, and obesity do not necessarily follow this operation. They feel that the patients should be informed that there may be little, if any, interference in their sex life. Huffman¹² studied a series of private patients who had been subjected to various gynecologic pro-

cedures and found that the sexual response was unchanged from that of the preoperative state. In one report it was stated that one of the patients had needed a hysterectomy was very much concerned about the fact that she might lose her sexual drive as a result of the operation. She also needed a pelvic repair, so it was decided by the surgeon that he would do the pelvic repair and also the hysterectomy, but not let the patient know about the hysterectomy. This was done, and the patient had no change in her sexual adjustment.

I feel sure that patients have much feeling about the removal of a breast, not only from the cosmetic effect, but also from the feeling of castration anxiety. Cockerill¹³ reports in detail about the feelings of a 50-year-old white, widowed woman who had to undergo a radical operation for removal of her breast as a result of cancer. The patient had much difficulty accepting the operation and made such remarks as, "I can't help but think of the way I am going to look. I never wanted any part of my body removed. This will make me lopsided." She finally indicated that even though she was 50 years of age, she frequently thought of a future marriage and felt that the breast amputation would definitely keep her from being able to be married again.

It was reported in the *Yearbook of Neurology and Psychiatry*, 1955¹⁴, that several women undergoing mitral surgery showed extreme anxiety, and it was felt that this anxiety influenced the outcome of the operation. One woman who expressed the fear that her heart might stop beating was the only person who had an operative cardiac standstill. Another woman who died 21 hours after the operation was terrified that she would not survive. It was stated that in several cases, the psychological defenses were inadequate and unsuccessful to such an extent that the patients bordered on a psychosis. Bliss et al¹⁵ reviewed 37 case records of patients that had mitral surgery. They found that three of these patients developed a schizophrenic reaction, and one patient who already had schizophrenia developed an exacerbation of his psychosis following surgery. There were also several cases of postoperative organic confusional states. Added to these were a variety of neurotic reactions.

Shanahan¹⁶ reported a followup study five years later on 25 patients that had vagotomy. He brings out several interesting points that might be helpful in making decisions in treatment of patients with peptic ulcer with surgery. He states that the man who will get a satisfactory functional result from vagotomy is one who shows longstanding successful reaction formation against his dependency, with a history of many years of steady, conscientious, fairly successful work. The individual who will have a poor

functional result is a man who had openly accepted his dependent inclinations throughout the years and has had them fairly well satisfied. In this series of 25 cases, 16 received a good functional result.

The analysts generally agree that in the majority of cases, for women an operation will become a delivery with all the fears and anxiety pertaining to the birth of a child. In man, on the other hand, castration stands in the center of the experience. At times a state of euphoria is observed after unsuccessful suicidal attempts or even a manic reaction, like being reborn. It is felt that this same kind of reaction is seen after an operation with some people.

Deutsch¹⁷ felt that the kind of narcosis on the one hand, and the organ operated upon on the other, determine the form in which anxiety is expressed. She felt that operations on important inner organs, especially on the genitals, like general narcosis tend to bring more death anxieties and that operations on peripheral organs and spinal local anesthesia result in more castration and anxiety. It is not very often that surgery relieves somatic symptoms of a neurosis, and it never relieves a delusion of a psychosis. It is felt that unless psychiatric supervision is maintained, relief from psychosomatic symptoms may prove catastrophic. A few patients who have psychoses and have to be operated on actually have a remission of their psychoses immediately after the operative procedure. Many people welcome an operation because it is a temporary relief from hard work and dullness of life and poverty. Other neurotic individuals welcome the operation because to the unconscious mind it represents a physical punishment.

Michaels¹⁸ emphasized the importance of preparation for an operation, especially with children. It is felt that the operations performed during the first six years of life, at puberty, and the climacterum are most traumatic. Michaels also points out that you can expect more psychological trauma as a result of hysterectomy if the patient is 35 to 45, unattractive, non-married, and a virgin. He also emphasizes the organ significance and states that organs that are especially prone to be invested with conscious and unconscious significance are the generative organs, eyes, and skull. It was felt that if a person had a pre-psychotic type of personality he would be more apt to develop a psychosis. The neurotic person would likely have accentuation of the previous neurotic pattern. If a person had a compulsive neurotic pattern, problems of aggression, rage, and guilt may be more dominant symptoms that might develop. If he were an anxious, hysterical type of individual, the erotic features would be more in the foreground. If the individual had a tendency to be suspicious, he might come to look upon the operation as having deleterious effects upon him.

It is obvious that just a few of the surgical procedures that frequently produce emotional illnesses have been reviewed. Some of the other conditions that frequently produce emotional upheavals following operations are thyroidectomy, thoracoplasty, and colostomy. Occasionally, one is able to predict prior to surgery the patients who are likely to have a psychotic reaction. Preparation of the patient for the operation is extremely important, especially if it involves the genitals, eyes, or if a prosthesis is necessary. The importance of preparation of a patient for an operation is frequently proven by the fact that some of the patients even become psychotic prior to the operation.

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The General Practitioner and Eye Complaints

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RECENTLY WE HAD occasion to discuss the eye problems which frequently confront the general practitioner. It is often difficult to determine exactly which ocular conditions are serious and which ones are benign. Of course, this question is more important in towns and communities where there is no ophthalmologist available, and consultation necessitates an inconvenience to the patient as well as a delay in beginning treatment.

Most eye complaints can be handled without special equipment, except for a bottle of two per cent sodium fluorescein and one of one-half per cent Tetracaine hydrochloride (pontocain, Winthrop Laboratories). It may be useful first to consider the eye symptoms which are reasonably safe to treat, and then to discuss those which are loaded with deeper and more alarming implications.

PART I

Foreign Bodies and Abrasions

Patients usually assume that any doctor can remove foreign particles trapped beneath their eyelids. Instillation of a drop of pontocain anesthetic helps one obtain more cooperation, and this allows a better search for the offending particle. The easiest method of everting the upper eyelid is to roll it over a match or tooth pick. Removal of the foreign body with a cotton applicator stick is safer than with a sharp metal object which might perforate the cornea or inoculate infection, should the patient move his head suddenly.

No foreign body can be found in half of the patients who complain of something in their eye. In these instances, two per cent fluorescein should be dropped into the eye and then washed away with normal saline. Most of the time a tiny green spot will appear on the cornea, indicating the presence of an abrasion.

Treatment consists of one drop of sulfamethylthiadiazole (Thiosulfil, Ayerst) followed by a patch for the next 24 hours. Pain from a corneal abrasion is often quite severe and may not be relieved by the usual analgesics, in which case a drop of the pontocain may be instilled every hour or two for several times. Prolonged use of pontocain is contraindicated because it delays healing.

Conjunctivitis

Acute conjunctivitis is usually obvious in its sudden onset and purulent discharge, with normal vision.

Cold compresses and Thiosulfil eye drops every four hours usually relieve the bacterial types within two or three days. Early treatment by the family doctor is much preferred to care by a specialist if the latter entails delay.

Chemicals

To be effective, any treatment for chemical burns of the eye must be prompt. Immediate irrigation with copious amounts of water is necessary. A very good method is to hold the head under a water faucet with a fine stream of water running into the eyes while the eyelid are forced open. An essential part of the emergency treatment for alkali burns is eversion of the upper eyelids and further irrigation, because small particles, such as granules of lye, may become trapped in the upper cul de sac and slowly dissolve, thereby producing more and more damage to the eye.

Lacerations

Ordinarily lacerations of the eyelids are easily irrigated and sutured, but if a cut extends through the lid margin, it must be repaired in such a way as to prevent the later development of a notch. This is a conspicuous cosmetic defect. A simple method of preventing this complication is outlined in the drawings. (Figures 1 and 2) The skin is excised on each side of the wound converting a linear defect into an elliptical one. The underlying tarsus is sutured first. The skin is undermined and approximated later. This two-stage closure prevents the formation of a single scar through the entire thickness of the eyelid, and the ugly notch is avoided.

Subconjunctival Hemorrhage

Subconjunctival hemorrhage is a condition which often frightens the patient, but it is seldom of any consequence. It occurs spontaneously in eyes which are normal in every other respect. Treatment consists primarily of reassuring the patient that the condition will subside in a week or so. In those few cases which are recurrent, the patient should be studied for disease of the blood or cardiovascular system.

Itching

Some eye complaints are better treated by the family doctor than by the ophthalmologist. An example is the persistent bothersome itching and burning sensation of the eyes and eyelids which may even keep the patient awake at night. It is associated with no objective signs whatever, except for a slight redness of the skin where he has been rubbing and

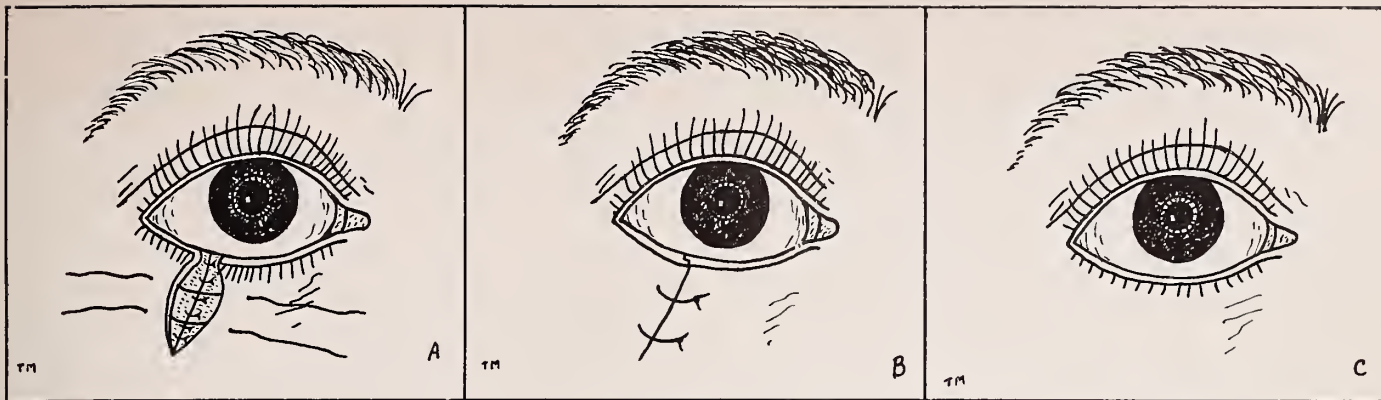


Figure I
Laceration through lid margin. Correct method of repair.

scratching. This seems to resemble the “neurodermatitis” which is seen elsewhere on the body. Cold compresses applied several times a day may afford some relief; however, the most important treatment is that which is directed toward the patient as a whole. An irritable or agitated general state is usually the underlying cause for this symptom.

Atopic Dermatitis

A closely allied condition is atopic dermatitis of the eyelid, which, however, presents definite objective signs. In addition to the itching, there is conjunctival injection and a thickening of the dermis of the lids, with exaggeration of the minute folds, and faint pigmentation. The family doctor is much more likely to discover the underlying allergen than is the ophthalmologist. If the condition is mild, Thenylpyramine ointment (ophthalmic-histadyl, Lilly) applied to the eyes and eyelids several times a day may prove extremely effective. If the inflammation is severe enough to cause oozing, then Prednisolone acetate with Neomycin sulfate (delta-neo-cortef, Upjohn) should be applied four times daily.

Ocular Neurasthenia

Ocular neurasthenia is a condition best treated by the family doctor. Rarely is there any indication for the prescription of glasses. The characteristic complaints are: frontal headache, lacrimation, and a feeling of fatigue when reading or watching television. If symptoms have been present for several months,

it is advisable to treat the patient systematically for a week or two before advising eye examination and refraction. Analysis by the practitioner will usually reveal evidences of neurasthenia, overwork, or lack of sleep. He may find definite signs of chronic disease. These poor patients often decide for themselves that what they need is eye glasses. They frequently fall victim to someone selling them a pair of blank or tinted glasses. It is odd how this “blood letting” seems to reduce the severity of their symptoms for a time.

Blepharitis

Some individuals are constantly bothered by scaly eyelashes and red lid margins. There is no permanent cure for this condition. It is commonly found as a complication of seborrhea, in which case treatment of the scalp will relieve the eyelids. Hot compresses several times a day and Bacitracin Ophthalmic ointment (Pfizer) applied at night will often help considerably.

Styes

Styes can be cured by the application of hot compresses and thiosulfur drops three or four times a day. Ointment is less satisfactory for use during the day because it sticks to the cornea and disturbs the vision. If the sty is pointing it should be incised.

Papillomas

Benign papillomas, if no larger than two millimeters at the base, may be shaved off smoothly without

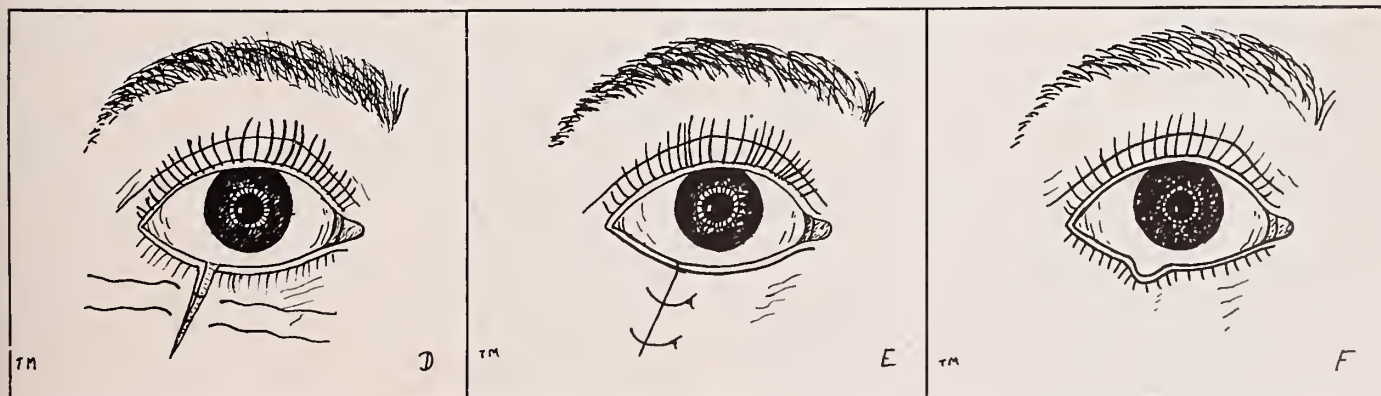


Figure II
Laceration through lid margin. Incorrect method of repair.

the use of sutures, and no cosmetic defect will occur. Pathological examination should be made of all such lesions excised from the eyelids because of the frequency with which malignant changes occur.

PART II

The following discussion is concerned with those eye symptoms which may seem insignificant, but which actually require immediate specialized care, either to preserve vision or to save the patient's life.

Visual Field Defects

One may easily be misled by a nervous type of patient complaining of among other things, a curtain hanging down before one eye. His vision may measure 20/20 on the charts. The underlying defect here is probably a detachment of the retina which will produce total blindness if not given prompt surgical treatment.

Sometimes a patient complains of blurred vision in one eye, and testing reveals equal vision bilaterally. He may have homonymous hemianopsia due to intracranial disease affecting the higher visual pathways on one side.

The complaint of bumping into things is always very serious, even if the patient can read the finest print. A likely cause is constriction of the visual fields as is seen with glaucoma or optic atrophy. Such patients may easily pass a driver's test, and yet be murderous on the highway.

Flashes of Light

If a patient sees flashes of light in one eye, his ocular fundi must be thoroughly studied through widely dilated pupils, because of the possible presence of a detachment of the retina, either of the serous type, or one secondary to a malignant melanoma of the underlying choroid.

Intermittent Blurring of Vision

Intermittent, transient blurring of vision in a patient with chronic headaches is suggestive of choked discs and intracranial tumor.

Exophthalmos

Exophthalmos may not be indicative of thyrotoxicosis, but of a thyrotropic disorder originating in the pituitary gland. Thyroidectomy may convert the condition into "malignant exophthalmos." Recently a patient was seen who had been treated for hyperthyroidism because her eyes were quite prominent, and there were minimal signs of increased basal metabolism. One eye was more exophthalmic than the other, however, and later surgical exploration of the orbit revealed the presence of an expanding tumor behind the eye.

Alkali Burns

Alkali burns of the eye must be regarded with caution, particularly those due to lye. The anions penetrate deeply into the coats of the eye, and there are two misleading developments. The ocular nerves are so inhibited that the patient may complain very

little, even after a serious alkali burn. Secondly, destruction of blood supply may be so extensive as to produce blanching instead of the usual hyperemic response of the conjunctiva to injury. Such a pale area may later develop necrosis and yet this very pallor can mislead one into believing the damage is slight.

Esotropia

Parents of children with crossed eyes are very often advised to do nothing until the infant is four or five years old, when refraction or surgery can be instituted. This is a dangerous practice. An immediate examination of the interior of the eye might reveal the presence of a malignant retinoblastoma. Even with those cases in which the optic fundi are perfectly normal with no evidence of tumor, treatment must be instituted early, to prevent the development of amblyopia. This is a condition which renders one eye almost useless in later life.

White Pupil

Frequently patients are seen with a white pupil. We cannot assume that this is indicative of a cataract. A tumor, retrolental fibroplasia, or exudative retinopathy may be the cause.

Glaucoma

How secure can we feel about the presence or absence of glaucoma? Halo vision may occur with incipient cataracts and vitreous opacities as well as corneal disease. A dilated pupil and a cloudy cornea likewise do not in themselves provide the diagnosis. Most textbooks over-emphasize the importance of palpating the eye in questionable glaucoma. This is unfortunate, because it is such a misleading test. Probably one-half of the questionable cases are diagnosed as having abnormally elevated ocular tension when it is entirely normal, and likewise one-half of the questionable cases are diagnosed as having normal tension when true glaucoma is present. There is no doubt that patients giving any indication of having glaucoma (positive family history, halo vision, severe pain, etc.) deserve to have their ocular tension measured with an instrument. Such an instrument may be obtained from Dr. Conrad Berens* who has developed a tonometer for use by the practitioner. It gives a reliable indication of the presence or absence of glaucoma.

Cortisone

Although the corticosteroids are extremely valuable aids in the treatment of many ocular diseases, these should not be used locally in the eye, except by an ophthalmologist. There are two reasons for this conclusion. First of all, they may obscure the diagnostic characteristics of the disease, while not really effecting a cure. In this manner definitive treatment may be delayed. Secondly, it has been shown that

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Georgia Hospital Care Commission

THE FIRST MEETING of the Georgia Hospital Care Commission was called to order by Dr. T. F. Sellers, Chairman *Ex-Officio*, on May 23, 1956, in Atlanta. After an opening prayer by the chairman, the following business was transacted:

1. Dr. R. C. Williams, Director of Hospital Services, read the resolution of the General Assembly of Georgia establishing the commission. There followed a short discussion of the purpose of the commission.

2. Members of the commission and other invited guests were introduced by the chairman.

(a) Members of the commission present: T. F. Sellers, Chairman, *Ex-Officio*, Director of the Georgia Department of Public Health; Mr. Allen Kemper, Vice-Chairman, *Ex-Officio*, Director of the Georgia Department of Public Welfare; Helen W. Bellhouse, Member, *Ex-Officio*, Director of the Division of Maternal and Child Health, State Health Dept.; Mr. Frank W. Allcorn, representative of the State Association of County Commissioners, Warm Springs; Mr. John H. Slagle, representative of the State Association of County Commissioners, Calhoun; Mr. Wiley P. Jackson, representative of the Georgia Hospital Association, Macon; Mr. Oscar S. Hilliard, representative of the Georgia Hospital Association, Fort Oglethorpe; Milford B. Hatcher, representative of the Medical Association of Georgia, Macon; Virgil B. Williams, representative of the Medical Association of Georgia, Griffin; Mr. M. M. Monroe, representative of the Georgia Association of Hospital Governing Boards, Waycross; Mr. F. L. Baker, Jr., representative of the Georgia Association of Hospital Governing Boards, Rome.

(b) Members absent: W. P. Harbin, representing the Medical Association of Georgia, Rome.

(c) Invited guests introduced: R. C. Williams, Director, Division of Hospital Services, Georgia Department of Public Health; Miss Helen Gillespie, Executive Secretary, Georgia Hospital Association; Miss Edwina Davis, *Atlanta Journal*; Mr. John Kiser, Assistant Executive Secretary, Medical Association of Georgia; Mr. W. E. Uzzell, Division of Hospital

Services, Georgia Department of Public Health; Grady N. Coker, Canton, Member of the State General Assembly.

3. Election of a Secretary: Mr. W. E. Uzzell was elected secretary of the commission. The motion was made by Dr. Bellhouse and seconded by Mr. Allcorn.

4. The following announcements were made by the chairman:

(a) An expression of regret by the chairman that no funds were appropriated to reimburse members for travel and other necessary expense relative to the work of the commission. To the extent possible, the following agencies and organizations promised assistance of some type to make possible the work of the commission: (1) Georgia Department of Public Health, (2) Georgia Hospital Association, (3) Medical Association of Georgia, (4) Georgia Department of Public Welfare.

(b) The chairman announced that the Governor had been requested to add two additional members to the commission to represent the General Assembly. The appointments will be made later by Governor Griffin after local elections have been held. Grady N. Coker was designated as Legislative Consultant to the commission. He attended and participated in the first meeting of the commission.

5. Appointment of Committees: The chairman appointed the committees listed below. These committees will meet as necessary to advise the secretary and the commission on the activities of the commission: Survey Committee: Mr. Frank W. Allcorn, Jr., Chairman; Dr. Milford B. Hatcher, Member; Mr. Wiley P. Jackson, Member.

Publicity Committee: Dr. Virgil B. Williams, Chairman; Mr. John H. Slagle, Member; Dr. Helen W. Bellhouse, Member.

Legislative Committee: Mr. M. M. Monroe, Chairman; Mr. Frank L. Baker, Jr., Member; Mr. Allen Kemper, Member.

Coordinating Committee: Mr. Oscar S. Hilliard, Chairman; Dr. W. P. Harbin, Member; Dr. T. F. Sellers, Member.

The G. P. and Eye Complaints (continued)

local application of corticosteroids in the presence of herpetic infection may worsen the condition to such an extent that later treatment is of no avail. The eye itself may be lost. Herpes of the eye can appear in bizarre form and never develop a typical dendritic ulcer. For this reason it may be hard to recognize.

Summary

When one considers the field of ophthalmology it

is surprising how many eye complaints can be relieved by uncomplicated means. Many are better handled by the family doctor than by a specialist. It is important to be alerted to those few ocular conditions which appear benign but have serious implications.

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Case Report:

Acute Allergic Reaction to Aspirin

COUNT D. GIBSON, JR., M.D., Richmond, Va., and IRA G. TOWSON, M.D., Sea Island, Ga.

IN AN ERA characterized by tension and strain, the consumption of aspirin (acetylsalicylic acid) in the United States has reached major proportions. The current annual production of this drug exceeds nine million pounds—an amount which provides an average of over 80 tablets per individual each year¹. Fortunately untoward reactions are rare. When they occur, the diagnosis may be easily missed in view of the benign reputation of the drug and the universality of its administration. The following case indicates the bizarre complications which aspirin can produce.

Case Report

The patient is a 66-year-old white married educator. He has always been free of allergic reactions or cardiovascular disease. Specifically, he has never suffered from asthma or anginal pain, except under the circumstances described below.

During the past decade, it appeared to the patient that ingestion of aspirin was often followed by gastric distress, and he rarely used this medication. Four years previously, in 1950, he suffered three attacks of chest pain accompanied by dyspnea within a six week period. A similar pattern occurred on each occasion. The patient would note fatigue and malaise. For these symptoms he would take aspirin 0.6 gm. (medication preceding the third attack was a capsule of unknown composition, presumably Empirin Compound (R)). Within an hour severe substernal pain and dyspnea would develop, subsiding slowly over several hours after administration of a narcotic. An electrocardiogram taken on the day following the first attack was normal. Physical examinations by several physicians during this period were unremarkable. A tentative diagnosis of acute recurrent cardiospasm was entertained. The patient sedulously avoided aspirin tablets thereafter on his own initiative and had no further difficulty.

On November 22, 1954, a dental extraction was performed on the patient under regional procaine block anesthesia. He was given a supply of Sal-Fayne (R) capsules, each containing acetphenetidin 0.15 gm., caffeine citrate 0.03 gm., and acetylsalicylic acid 0.2 gm. The patient returned home feeling well. Approximately two hours after the extraction he ingested one capsule. Fifteen minutes later, a dramatic sequence of events occurred: sudden onset of crushing substernal pain, acute wheezing dyspnea, angor animi, massive urticaria of the face, arms and legs, generalized pruritus, and vomiting. Dilaudid (R) one mgm. was given subcuta-

neously 15 minutes later and Pyribenzamine (R) 0.1 gm. intravenously after one-half hour. Following this therapy his symptoms disappeared rapidly, and he felt essentially well on the following day.

On December 27, 1954, a scratch test was performed on the flexor surface of the right forearm. A 1:1,000,000 aqueous dilution of acetylsalicylic acid was used. This produced a definite urticarial wheal 15 minutes later. At present the patient is asymptomatic.

Discussion

The production of anaphylaxis with an accompanying anginal type of pain by 0.2 gm. aspirin seems highly probable in this case. Such a relationship is supported by the positive scratch test in high dilution.

It is usually stated that allergy to aspirin occurs almost entirely in asthmatics. Shookhoff and Lieberman² reported three cases of hypersensitiveness to aspirin expressed by the anginal syndrome. In two there was accompanying urticaria. Evidence of hypertensive or arteriosclerotic heart disease was present in all three. The syndrome was reproduced in one patient by the deliberate administration of 0.6 gm. aspirin.

In our case, the source of the chest pain and its mechanism of production cannot be identified from the available data. It should be noted that the attacks of pain occurring in 1950 were not considered as allergic phenomena, since they were not associated with urticaria or asthma. We believe that other cases of atypical angina should be studied with regard to a possible hypersensitive etiology.

Summary

The case is presented of a 66-year-old white male, previously free of allergic or cardiovascular disease, who repeatedly developed chest pain following the ingestion of aspirin. During the most recent episode, crushing chest pain was associated with giant urticaria, wheeze, and vomiting. A scratch test for aspirin was positive.

Medical College of Virginia Hospital

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From the Department of Medicine, Medical College of Virginia (Dr. Gibson).

A New Approach to Mutual Problems

MILFORD B. HATCHER, M.D., Macon, Ga.

THE PHYSICIAN, by the very nature of his profession, is dedicated to the best possible care for the sick. May I now quote from the charter of your own American Hospital Association: "The responsibility of the hospital is to promote the public welfare through development of better hospital care for all the people."

The above, as I see it, are the only reasons you and I are occupying the positions we now hold. We all must remember that our two groups are responsible to God, mankind, and our community for the care of the sick.

There is then a necessity for a permanent wedlock between hospital (governing board and administrator) and physicians. This marriage must succeed not only to protect the patient but also to perpetuate the American ideal of free enterprise for hospitals and the medical profession.

To begin with, there now exists an incongruity whereby the legal and moral responsibility for the welfare and safety of the patient is vested in a lay governing board. This lay group is not qualified to judge the quality of patient care given by the medical staff. Thus a hospital is a unique organization in which management is frustrated in its incapacity to judge the quality of its product.

Thus we have a hospital whose sole purpose is the care of the sick. This care can only be given by physicians. The patient-physician relationship is constant, strong and abiding, whereas the services of the governing board are not. As a result, there frequently exists no direct line of authority by which policy adopted by the governing board can be enforced by its agent, the administrator. In such cases the authority of the administrator is either ignored or is not respected by either the governing board or the medical staff. As a result of this we have a "split body and a split personality."

There is only one answer—and that is to have a governing board which is qualified—one which will evaluate professional and administrative advice in order to discharge its responsibilities in the maintenance of adequate patient care. In order to alleviate any misunderstanding, all parties concerned—governing boards, administrators and physicians—must

have an insight into the others' problems and work out a mutually agreeable solution.

A simple standard that can be applied to every contingency as it arises is the spirit of the well-known Rotary Club "Four-Way Test":

1. Is it fair to *you*?
2. Is it fair to *me*?
3. Will it build goodwill and better friendship?
4. Will it be beneficial to all concerned?

If all persons concerned will ask these questions, almost any problem that arises can be settled to the satisfaction of all.

Let us now think back to the days of King Arthur and his band of knights which formed the patterns of chivalry. They met at a round table, as this arrangement symbolized their sharing as equals in service, no man being exalted over his neighbor.

The Medical Association of Georgia and the Georgia Hospital Association have attempted to follow the principles of the Round Table and have set up their committees to meet and discuss problems which affect both groups. It is realized that this joint state-level group cannot answer all of your local problems, but a similar organization within your staff could have the same function and effect.

The state-level committee is the one we will discuss in an attempt to bring forth some of the problems that face us and see if they can not be properly worked out. The American Medical Association and the American Hospital Association in 1953 adopted a report on "Relation of Physicians and Hospitals." We hope that in due time our state bodies will have adopted basic principles for guidance of Georgia physicians and hospitals.

Thus far, the two associations have jointly considered state legislation, which we felt was the most pressing at the present time. Working as one, we supported legislation that we felt would be beneficial for both organizations and thus aid in both of our objectives in care for the sick.

The first meeting was held with our efficient secretary and other members of our Association; our executive secretary; Dr. Coker, the legislative chairman; and myself, as chairman of hospitals. The major objectives were discussed, and then meetings were planned with key legislators and members of the Medical Association of Georgia and Georgia

Presented before the Georgia Hospital Association, February 24, 1956, Atlanta, Ga.

Hospital Association. Our viewpoints were presented to the legislators along with the reasons we felt they would help the people of Georgia.

Outside of the Joint Accreditation Board, there is only one other board which passes on requirements for approval of a hospital in this state. This is the State Board of Health which requires that the physical plant come up to its standards, but we do not have any requirements regarding the professional standards. The hospitals that are accredited by the Joint Commission qualify professionally, but we also are concerned about the other hospitals not accredited, more especially those below 50 beds. I do not think that it is generally known that the Joint Commission will accredit hospitals down to six beds, but seldom does one of the smaller hospitals request such accreditation.

One of the goals of the Medical Association of Georgia, which to reach we will need the wholehearted cooperation of the Georgia Hospital Association, is to encourage all other hospitals which are not approved by the Joint Accreditation Board to seek such approval. If not, then we desire to establish standards by which our own state medical association and hospital association can give such approval. In this manner we hope that we can elevate the professional and hospital care of patients and eliminate practices in hospitals throughout the state which are looked upon with disfavor by both of our organizations, and whose continuance is felt to be unfair and to the detriment of the people of Georgia. We hope that by circulating these standards, which are based fairly and consideration made for the size and location of the hospital, we can in this manner aid the governing boards and hospital administrators in the following professional problems:

1. Deciding who will have what professional privileges in the hospital.

2. Encouraging examination of all tissues removed during surgery.

3. Organizing refresher courses for laboratory procedures.

Your own organization has already instituted house-keeping and other standard-raising courses.

In order to promulgate the above, the Medical Association of Georgia has proposed that a Joint Commission be organized to set up these standards. It is to be composed of representatives of the Medical Association of Georgia, Georgia Academy of General Practice, Georgia Chapter of the American College of Surgeons, and the Georgia Hospital Association.

I would like to state before concluding that it is *not* the intention of this commission to work a hardship on any hospital or physician. Nor is it their intention to be a police force and be used as a whip. However, it is its sincere desire that by setting up these standards it will stimulate all hospitals to improve their care of the sick.

We have set sail—but most of our work lies in the future. With the enthusiastic cooperation which has been exhibited thus far by your organization, we feel that by using the old "Round Table" method our goals are not beyond the realm of possibility and can be reached.

I would like to close with this quotation from Charles Dickens, which I think is apropos to both our organizations:

"Mankind was my business; charity, mercy, forbearance, and benevolence were all my business."

781 Spring Street

Physicians Given July Induction Orders

THE FOLLOWING PHYSICIANS who are Special Registrants of Georgia have been ordered for induction in July, 1956, under Special Call No. 27:

Lewis Lamar Hatcher, M.D., Alma, Ga.
Donald C. Chait, M.D., Atlanta, Ga.
Waldo E. Floyd, M.D., Atlanta, Ga.
Albert R. Howard, M.D., Athens, Ga.
John G. Madry, Jr., M.D., Tampa, Fla. and Atlanta, Ga.
Edwin C. Pound, Jr., M.D., Atlanta, Ga.
Frank T. Robbins, M.D., Brentwood, Mo.
Frank Crane Wilson, Jr., M.D., Atlanta, Ga.
Tom W. Leland, M.D., Washington, D. C.
Frank W. Wouters, M.D., Washington, D. C.
Arthur C. Beall, Jr., M.D., Houston, Texas.

William K. Payne, II, M.D., St. Louis, Mo.

The following Special Registrant of Alabama is included in this call:

William C. Smith, M.D., Emory University Hospital, Emory University, Ga.

The following Special Registrants of Tennessee are also included:

Thomas F. Mogan, Jr., M.D.,
St. Joseph's Infirmary, Atlanta, Ga.
Warren F. Brown, M.D., Atlanta, Ga.

These men are ordered for induction on July 31, 1956, but are urged to apply for commissions. All are being allocated to the Navy. Registrants commissioned as a result of this Call will be ordered to report for active duty in October 1956.



Treatment of Phlebothrombosis

OCCASIONALLY ONE MUST PAUSE and reflect with a certain degree of skepticism at our faddist approach and vigorous enthusiasm for new methods of therapy in disease. This applies particularly to the use of a variety of chemotherapeutic agents in the management of phlebothrombosis/thrombophlebitis. In the absence of classical pulmonary infarction, it is frequently difficult to establish a positive diagnosis of peripheral venous thrombotic disease. The most dependable signs that exist are pain, local tenderness, and induration about the involved vein, along with increase in temperature, pulse, and sometimes the respiratory rate.

During the past 20 years, enthusiasm has prevailed at one time or another for different modalities of therapy. To mention a few: anticoagulants, peripheral vein ligations, vena cava ligation, and independently or associated with the foregoing conservative therapy consisting of bed rest, elastic bandages, and analgesics. There are proponents of each and all. Though no adequate statistical analysis of a controlled group of patients treated without drugs or surgery has been published, various observers claim excellent results for such ultra-conservative, and very often, most wise methods.

Elsewhere in this issue, (see page 351) the effects of a new type of treatment for patients with thrombophlebitis are described. The results are good, the study has been carefully done, and no one would deny that the agent (trypsin) has proven to be most effective. At the same time, it must be realized that here is an approach to the problem that is very alluring. Administration of this drug is almost without hazard, and no local or general toxic manifestations of significance have appeared. It has the advantage of avoiding the insults of surgery as in venous ligation procedures. Proven to be more economical, it can be handled with far less laboratory control than the anticoagulants and does not produce the ever-present problem of possible bleeding or idiosyncrasy that these latter drugs do. Most fascinating to the surgeon is the facility with which trypsin may be used in the immediate post-operative period without fear of wound hemorrhage.

Without equivocation, in one situation or another, each type of therapy mentioned has been of utmost benefit. The discerning physician will continue to use

diversified methods in the treatment of phlebothrombosis, setting as a pattern for treatment the need of his individual patient—not the least difficult route established by any one simple method.

Renal Hypertension

NO THEORY CONCERNING the pathogenesis of hypertension can of this date afford to ignore the kidney, but opinion regarding the mechanism by which it participates is sharply divided into two camps.

Hyper-renalism is the older view. It rests largely upon demonstrations that blood pressure rises when the pattern of renal blood flow is altered and falls again when the affected kidney is removed, that kidney extracts contain pressor substances, that an excess of renin has been detected in the plasma of some patients with hypertension, that experimental hypertension has to some degree been favorably influenced by specific anti-renin sera, and that some patients have been cured of hypertension by the removal of a diseased kidney. It argues that an excess of renal pressor substance could be more regularly demonstrated in the blood of hypertensive patients if analytical methods were sensitive enough.

Renoprivalists on the other hand believe that hypertension is a deficiency disease since it appears after bilateral nephrectomy in animals whose lives are prolonged by artificial means, and since both experimental and human hypertension have disappeared following auto- or homo-transplantation of a kidney. Since it is easier to find an excess of renin in the blood of patients in shock than in those with hypertension, they feel that this phenomenon represents the response of the kidney to circulatory failure, the *renin-angiotonin complex* having the ability to sustain blood pressure and glomerular filtration rate in the face of a diminished renal blood flow and to reduce the oxygen requirements of the ischemic kidney. They have difficulty, however, in explaining the occasional brilliant therapeutic response to nephrectomy except as an illustration of the fact that even the most useful homeostatic response may sometimes go astray. They are unimpressed with the possibility that over-activity of the kidney is responsible for sustained hypertension and prefer to believe that normal kidneys either excrete or metabolize vasoconstrictor substances coming from extra-renal source, possibly



EDITORIALS

(Renal Hypertension cont'd)

the adrenal cortex. It is also possible that renal epithelium normally secretes depressor material.

The arguments *pro* and *con* are intricate and unconvincing, for even the classical Goldblatt clamp experiment can be interpreted in either view. About all that may safely be said at the present time is that the most significant forms of experimental hypertension seem to result from a mysterious interplay between the cells of the renal tubule, the sodium ion, and certain steroids from the adrenal cortex.

There is little of immediate value here to the practitioner and his patient with uncomplicated hypertension, but prospects for the future seem bright. A low-sodium diet may be useful to a point in the management of edema, but it is essentially a self-defeating procedure in that it also leads to an increased output of aldosterone, the most potent salt-retaining steroid yet discovered. Total adrenalectomy has not attracted many disciples as yet either, but specific anti-steroidal drugs are being developed. However effective surgical or chemical sympathectomy may be in lowering manometric readings, there is little scientific evidence to support the idea that hypertensive patients have overactive autonomic nervous systems. Although all past attempts to isolate useful depressor substances from the kidney extracts have failed, preliminary experiences with kidney transplants in identical twins justify the hope that kidney banks may become feasible when the antibody problem is solved. In the meanwhile the alert clinician continues to search for the occasional patient who needs nephrectomy; he will likely be a young person with severe hypertension of short duration or an older one whose benign hypertension suddenly becomes accelerated in tempo and severity. Unilateral lesions of the kidney itself should be demonstrable by conventional methods, but lesions of the renal artery require translumbar aortography. Even the most careful studies will not insure success in every case, but nephrectomy is a justifiable attack against an enemy as deadly as malignant hypertension when the opposite kidney is thought to function adequately. The patient with benign hypertension and unilateral renal disease had better still be managed at the symptomatic level, however, unless the kidney needs to come out for urological reasons.

Pierce G. Blich, Jr., M.D.

Georgia Heart Association Laboratory for Cardiovascular Research, Medical College of Georgia, Augusta, Georgia.

Ethics

ETHICS IS DEFINED as the principles of right conduct. Behavior is ethical when right, unethical when wrong. As physicians we subscribe to a code of ethics as high as that of any secular profession and as individuals live up to the code very well. The corollary is that what is unethical for the individual should also be unethical when individuals are joined together in a group. As Peter Marshall Murray pointed out, groups should not be permitted to do that which is considered wrong for the individual. Unfortunately, this precept has been ignored in recent years with increasing frequency. When banded together in a medical college, hospital, clinic or health organization men often stoop to practices which as individuals they abhor.

Under the code it is unethical to advertise, solicit patients or make claims of superior skills, and three things distinguishing the ethical practitioner from the charlatan are that the ethical physician neither advertises, solicits patients nor claims special talents. As individuals we adhere tenaciously to these principles. But sometimes men of the highest personal integrity, who would defend their honor by physical combat if accused of being unethical, permit these practices in a scientific study, the operation of a diagnostic center or some similar program under the aegis of medical school or hospital.

If individuals must observe rules they should not countenance disregard of the rules by institutions with which they are connected. Physicians in professional and policy-making positions are especially wrong in lending their names to such enterprises, and when approached about the establishment of facilities to be operated contrary to the code should have the courage to resist. This is, of course, easy to say when one is not on the firing line, but even those not directly involved may be of service in the cause of good practice. Knowing of intended projects we should encourage physicians in positions of influence to adhere to principles. Often these persons are under merciless social and economic pressures—a heartening word at the right moment may steel a flagging valor.

Colleges and universities are presumed to be citadels of high morality and framers of patterns for righteous conduct. When medical schools and hospitals under their control sponsor unethical practices they are guilty of grave immorality, for they not only flout proper standards, but also encourage their being ignored by other institutions and individuals because their plans of operation are followed as are their

Reprinted from *Philadelphia Medicine*, 51:1541 (June 26, 1956).

Spalding County—Cleanest in the U. S.

THE CLEANEST PLACE in the entire United States for eating out is Spalding County, Georgia.

That's what the experts say. It didn't happen overnight, either. The health people and the restaurant people worked hard for four years to make it that way. In official language, the county's food sanitation program has just been rated as being in 93.32 per cent compliance with U. S. Public Health Service standards by Mr. W. R. McLean, milk and food consultant, Public Health Service, and Mr. M. H. Trippe, food sanitarian, Georgia Department of Public Health.

Mr. McLean said the program enjoys the highest official rating he has ever given and, to the best of his knowledge, is the first in the nation to exceed the 90 per cent mark as established by the Public Health Service on evaluations conducted and supervised by that agency.

Congratulations came from T. F. Sellers, director of the Georgia Health Department, who said he would like to see citizens and tourists get the same health protection in every other county in Georgia as well.

The program was directed by J. R. Thomas, county health commissioner, and carried out by Mr. M. P. Moore and Mr. H. M. Smith, sanitarians. In almost every case the program was welcomed by restaurant operators and employees, and it received the cooperation of newspapers and radio stations as well as guidance from the Georgia Department of Public Health.

Spalding County was not very happy with its rating four years ago of 70.59 per cent. The Health Department began a program to provide the latest in educational material and training programs for food service personnel and management. Attendance and interest were high. Thorough inspections were made

to familiarize operators with modern health and sanitation practices. As knowledge increased, enthusiasm grew and progress followed.

By October 1955 the county's rating was 86 per cent, the third highest in the nation. In a little over five months Spalding County moved to the top and Dr. Thomas says he hopes to keep it that way.

Effect of Chewing Tobacco

ALTHOUGH THE ANNUAL CONSUMPTION of chewing tobacco in the United States is 81 million pounds, practically no information is available about its clinical or physiological effect and specifically its effect on the heart and circulation. Accordingly, habitual male chewers were studied before, during and after chewing both standard commercial (1.53% nicotine) and low nicotine (.31-.47%) tobacco.

Our subjects were 24 voluntary habitual male chewers whose ages ranged between 34 and 71 (average age 51.2). Each subject chewed a full mouthful of low nicotine chewing tobacco (gum was used in several subjects as a placebo) and a regular commercial brand on the alternate day. The average amount of tobacco chewed weighed 10 grams. Observations were made in the basal postabsorptive state following a rest period of at least 45 minutes.

Conclusion: The chewing of tobacco in an older group of habitual male subjects produces increase in pulse rates, blood pressures, and drop in skin temperatures, as well as deterioration of the ballistocardiogram, indicating a rather profound cardiovascular effect.—*David L. Simon, M.D., and associates at University of College of Medicine, in paper presented before second annual meeting of the American College of Augiology, Chicago, June 10, 1956.*

Editorials (continued)

diagnostic and therapeutic methods. Hard pressed as institutions of higher learning may be for funds, they should, nevertheless, resist the blandishments of philanthropists and foundations when gifts from these donors are accompanied by provisos contrary to the fair principles on which our country has prospered. Only in this way can they remain bulwarks of correct conduct. Though insidious and indirect, the practices of educational institutions can foster, by example, the adoption of socialistic principles which eventually will be just as ruinous to our way of life as governmental espousal of collectivism.

Since we, as an organization, are keenly aware of the need for defending the health interests of the

community and realize that the code gives even greater protection to the public than to physicians, we should support it by reaffirming publicly from time to time our belief in its principles. It is also our duty, in terms of simple justice, to uphold our members who, in spite of the danger of incurring the wrath of those in the high places, protest infractions of the rules. Furthermore, we should also censure both individuals and institutions violating the tenets of medical morality, for on these tenets American medicine has won the proud position it occupies on the roll of the professions.

*John T. Farrell, Jr., President
Philadelphia County Medical Society*

president's letter



HERE IN GEORGIA at the present time, the problem of greatest concern to the members of our profession consists of our disagreements about our medical schools. Some of these disagreements, not yet recognized officially, are causing trouble between individual doctors as well as between the institutions and the medical societies.

The answers on the questionnaires and the information obtained through the report of various committees of the American Medical Association show that similar conditions exist in many other states. Alaska, Arizona, the Canal Zone, Delaware, Hawaii, Idaho, Montana, Nevada, New Jersey, New Mexico, Rhode Island, and Wyoming have no medical schools. All the other states and affiliated territories have one or more. The schools are divided almost equally between state supported schools and private schools. Practically all of these schools have difficulty meeting their budgets. Ninety-seven per cent of the schools answering the questionnaires of the AMA claim that to keep teachers of the desired caliber they need to augment the salary which the school can afford to pay them; without the proper teachers, they could not maintain the proper educational standards. In addition, most of the schools need more funds to support the research necessary for teaching, for the continued advancement of medical science, and for post graduate education. More money is necessary to send the faculty, fellows, and residents to medical meetings or for investigation of scientific work being done in other teaching and research centers.

At the present time grants from various organizations and from foundations help the schools some, but they are still insufficient to meet the needs. And they do not furnish a source of funds which can be relied upon from year to year. So, most of the schools are resorting to the practice of medicine by the absolute full time salaried professors to overcome the deficits in their budgets.

Another reason for having private patients is that they are needed to afford the proper amount of clinical material for teaching. Voluntary insurance of various types has markedly decreased the number of indigent patients available for teaching purposes.

From all the information available at the present time, it is evident that the schools have made no concerted effort to coordinate plans concerning this practice or concerning the use of the income derived

from it. In one school the members of the faculty receive no pay for teaching, but the faculty members have organized a private clinic separate from the school which they run with a manager of their own, and they receive all income from their work. The school furnishes the clinical professors space, heat, lights and water, but this is all they get for their teaching. They use all the time necessary for teaching, but beyond that there is no limit to what they can earn by their private work. The school receives no money from them except for the fact that what money the school would have paid them for teaching is used for other purposes. All full time members of the clinical faculty automatically become members of the clinic.

In some schools the full time faculty are on salary and receive no other remuneration. Bills for their services to patients may be sent out to the patient by the doctor, but checks are either made out to the hospital or to the college for some special fund, or if they are collected in the doctor's name, he simply endorses them to one of the above. In other hospitals, the bills are sent and collected by the college or by the hospital. The proceeds go either into some special fund or into the general funds for the institution.

Between these two extremes there are all kinds of other methods of charging, collecting, and using the income produced by the practice of the full time faculty.

No doubt, within the near future, the Council on Medical Service or some other committee of the American Medical Association will present a more or less definite report on what may be considered legal, ethical, and acceptable from the standpoint of organized medicine. We do not know when this report will be published. When it is made available for general use, it is hoped that a solution will be arrived at which will meet the financial requirements of the medical schools and be acceptable to the local doctors and societies, where the schools are located. Certainly, neither the medical schools nor our profession as a whole can exist one without the other. They must get together and help each other. It can be done, but very few of the schools and their deans have approached the solution to their financial problems from this standpoint. In most localities, the local doctors are dissatisfied and embittered against their brothers teaching in medical schools, many of

whom do not belong to a local society, do not know their fellow doctors personally and apparently do not care anything about local problems. Some of the local doctors say the professors live in their ivory towers far above the practice of medicine, they enjoy a reputation and glamour bestowed by the position and title of professor, which is not justified by fact, and in some instances indulge in publicity which amounts to advertising which would not be tolerated when used by a practicing physician. They accept patients, refer them about among themselves, and give little help to the family doctors who treat them. Some of the schools and some of the professors have shifted their main interest from teaching and spend too much time in private practice and in making money. They are competing with the local doctors and have an unfair advantage over them because of their position, because of advertising, and because of being subsidized by the institutions in which they teach. Some of the doctors are particularly bitter about those professors in state institutions, saying that their own taxes are subsidizing the men who are competing with them. They accuse the state of entering the corporate practice of medicine, and say that the state should no more practice medicine than it should practice law in competition with the lawyers.

Some professors, particularly the younger ones, have been accused of making slurring remarks about doctors who have referred patients. Some doctors say that when their patients go to these teaching institutions they have little personal care or interest from those who treat them. All of this has made some practicing physicians and some local societies claim that there is only one answer to this problem: full time salaried professors in medical schools must not do private practice. This is one extreme and one alternative.

Many practicing physicians, however, and some local societies do not agree with this conclusion. In the first place, if we physicians and our societies do not understand the problems of our medical schools and help them, what is going to happen to the medical schools? What is going to happen to our profession? Medical education is now at an all time high and is still improving; it either will continue to progress or it will deteriorate. If the finances necessary for medical education are not obtained in some other way, the federal government will subsidize the schools and eventually take them over, and with the schools, the medical profession itself. They claim that private practice for teaching professors is necessary and the lesser of the evils, from a financial standpoint. In addition, they believe that private practice for teaching professors is necessary for their own good. It brings them down from their ivory towers, makes them human, and helps them give students,

interns, and residents a view of practice which cannot be obtained by treating only indigent patients. It is also claimed that this private practice can be done in a way which aids the local practitioner and does not compete with him. It can give the private doctor access to consultation service of the highest type and the patient the type of diagnosis and treatment that he needs; and the patient returns to the practicing physician for continued care. In addition, the full time salaried teacher can practice, collect bills, supplement his salary, and have some funds left for his department for research and other purposes mentioned above. This can be done in a legal and ethical manner which will be acceptable to the local doctor and local society.

To begin with, in most states, the corporate practice of medicine is illegal. The simplest definition of the corporate practice of medicine is "the charging by an institution or by some corporate group for medical services rendered by a physician." In some localities, non-profit institutions claim they should be exempt from abiding by this definition. In various states there are being handed down by attorney-generals' decisions concerning this matter, and, in other states, law suits are in progress to settle the matter. So far, in practically all of these states where the law exists, decisions and results of lawsuits are in favor of abiding by the simple definition of the corporate practice of medicine stated above.

The code of ethics of the American Medical Association states that a doctor cannot sell his services for profit. Neither can he enter into an agreement with others which allows the exploitation of his services to patients or which interferes with the patient's free choice of physicians.

Non-profit institutions claim they are working for the good of patients, that they pay a salary to doctors which is satisfactory to them, and there is, therefore, no exploitation, and that patients voluntarily come to certain hospitals and their staffs, which amounts to their choosing doctors who are available under the circumstances. These matters are being settled in some states and in some communities in a manner which is legal, ethical, and satisfactory to the school administration, to the teachers themselves, and to the local doctors. Therefore, it is acceptable to the societies.

From all the various plans used, we select what might be considered a composite of these measures which have aided most in the accomplishment of this situation and recommend that:

1. The dean and his teaching staff belong to the local society, know its members personally, and take part in the programs and in the administration of the society. They become an integral part of local medicine.

2. When any plan is being formulated for using full time salaried professors in private practice, the dean shall not ignore local doctors and ride roughshod over their opinions and desires. He should not antagonize them but rather make his plans, take the doctors into his confidence, discuss with them all the details of what he needs to accomplish and how he proposes to accomplish it. Doctors are like all other human beings. They are suspicious of what they don't know. By the above method the dean will get their advice and enlist their aid instead of creating antagonism. In one instance officers of the state society instituted and carried through the discussion with the dean and his committee, when it was evident that trouble was going to come. As a rule the dean first works with the Board of Trustees or with a special liaison committee from the local society until the plan of action is perfected and accepted by the committee; then it is taken to the whole society for its approval. Having been accepted by the local society, the plan is carried to the state society and usually accepted as is.

The liaison committee of the local or the state society, one or both, should continue to function and at regular intervals have conference with the dean or some administrative committee of the school.

3. The size of the teaching hospital should either be limited as to the number of beds required for teaching purposes, or at least not made so large that the administrator must use all possible means to keep it filled.

4. Patients: All patients accepted in the hospital must be referred.

(a) Each private patient must be either referred in writing by his physician, accompanied by his physician, or referred first by a phone call and then have this reference confirmed later by a letter. Free choice of physicians is retained, and the patients may be referred to specific doctors on the staff. If referred to the institution in general, of course, the proper doctor is selected according to patient's illness. It is understood that all private patients are to be used for teaching purposes and with a limited number of beds available, the patients admitted must be selected as having value from the teaching standpoint. Private doctors are always given complete reports and all possible help in diagnosis and the future care of the patient.

In one institution the referring doctor has the privilege of visiting the patient and studying with the consultant the progress of the diagnosis and treatment. Presumably for the time his patient is in the hospital, he belongs on the courtesy staff.

(b) Other patients, that is, those patients who can pay the hospital but not the doctor, or indigent patients, may be referred by their physicians or by various agencies recognized as having the authority to do so. Only patients with recognized emergencies are accepted without definite reference.

5. The teachers should have facilities in the hospital for examination of patients, either private offices or general offices which they use in common. The institution charges the practicing doctor for all space and for all service rendered to him for use in his practice. This removes all idea of subsidization.

6. Some limitations must be placed on the practice allowed teaching professors. The amount of practice that any one professor may undertake may be limited by the number of beds he is allowed. In other institutions there is a specific time limitation put on the amount of time the professor may spend with private patients. In others, there is a limit to the total income that may be collected. Then, of course, acceptance of only those patients who are referred by doctors also limits the practice. However, in no instance must the time allowed for private practice be sufficient to interfere with the teaching or research duties.

7. Charges must be made by the teachers themselves for their services and must be in keeping with local fees.

8. The teacher then should make his own charges, send his own bills, and collect his own fees, or have them collected by a central business office in his name.

9. The collections should be either credited to the doctor or to his department in his name and later disbursed according to a plan agreed upon by the doctor who made and collected the fee, and the general scheme be approved by the dean.

As a rule, the salaries of doctors are augmented up to a certain percentage of their base salary paid by the institution. Part of the remainder is used for departmental development, part to finance research projects, and perhaps some for necessary educational travel by professors and residents.

At the end of the fiscal year, any residue not used up by the above means is donated to a general development fund for the college, in which all departments may participate as necessary.

At any rate, by this method the doctor practices medicine, sends his own bills, collects his own fees, and says what shall be done with the money obtained.

The medical school, on the other hand, derives benefit and financial support without entering the corporate practice of medicine.



President



physician's bookshelf

Books Received

Diggs, L. W., M.A., M.D.; Dorothy Sturm; and Ann Bell, B.A.: *The Morphology of Human Blood Cells*, W. B. Saunders Company, Philadelphia, 1956, 181 pp., \$12.00.

Dragstedt, Carl A., M.D., Ph.D.: *Personal Health Record*, The Military Service Publishing Company, Harrisburg, Pa., 1956, 64 pp., \$1.00.

Gross, Harry, M.D., and Abraham Jezer, M.D.: *Treatment of Heart Disease, A Clinical Physiological Approach*, W. B. Saunders Company, Philadelphia, 1956, 549 pp., \$13.00.

Major, Ralph H., M.D., and Mahlon H. Delp, M.D.: *Physical Diagnosis*, W. B. Saunders Company, 1956, 358 pp., \$7.00.

Sadove, Max S., M.D., and James H. Cross, M.D.: *The Recovery Room*, W. B. Saunders Company, 1956, 597 pp., \$12.00.

Reviews

Williams, Robert H., M.D. (Editor), **TEXTBOOK OF ENDOCRINOLOGY, Second Edition**, W. B. Saunders Company, Philadelphia, 1955, 776 pp., 175 fig., \$13.00.

This volume is a collection of essays on 13 subjects in the field of endocrinology. The editor and his collaborators attempt to survey the field and to relate this information to other areas of the practice of medicine. The utilization of 10 authors in a work this size constitutes the prime advantage of the book. This leads to an excellent treatise where the author is an acknowledged authority; and, of necessity, demands some wide shifts of approach by the reader as he passes from one section to another. Duplication of material occasionally occurs as in the discussion of "ACTH" in the chapters "The Pituitary" and "The Adrenal"; but this is infrequent and the different approaches should be refreshing. The book is to be commended on the introductory chapter where the editor discusses fundamentals concerning the actions of endocrine glands and hormones. The section on adrenal insufficiency is extremely well done particularly as to diagnosis, clinico-physiologic correlation, surgery in adrenal insufficiency, and adrenalectomy. No mention is made of the use of androgens in primary adrenal insufficiency. The fluorinated derivative of hydrocortisone, hydrocortisone hemisuccinate, prednisone, and prednisolone are discussed briefly. The chapter "Neuroendocrinology" treats the hypothalmo-hypophysial system in some detail. Interesting theories are presented on the relation of some psychogenic disorders to the hormones. The discussion of obesity gives adequate attention to emotional factors in overeating. The chapter on the relation of the endocrine glands to growth and development is basic and well supplied with tables and charts on statistics, osseous and dental development, and diagnostic possibilities. A list of available hormone preparations is submitted, but the almost impossible task of including the trade names was not attempted. The section on the laboratory procedures explains the principles of interpretation of numerous hormonal assays and determinations.

This book fulfills its purpose amazingly well. It is pleasant reading, and it gives surprisingly detailed and up-to-date information. It will be particularly helpful to the internist; but the inclusion of a pediatrician, a urologist, and a gynecologist among its authors make it certain to provide helpful and useful information to all members of the medical profession.

Ernest W. Beasley, Jr., M.D.

Sternberg, Thomas H., M.D., and Victor D. Newcomer, M.D., **THERAPY OF FUNGUS DISEASES**, Little, Brown and Company, Boston, 1955, 337 pp., \$7.50.

This valuable book represents a symposium of papers that were presented on June 23rd, 24th, 25th, 1955, at the

Department of Medicine, School of Medicine and Medical Extension at the University of California in Los Angeles. It was quite properly sponsored by the dermatological faculty of the University of California, and was made possible by the financial assistance of the Squibb Institute for Medical Research. It is a book that every dermatologist should have in his library, and certainly those interested in mycology should read and have it at hand.

While the symposium is somewhat overweighted with research work and clinical descriptions of the use of Nystatin, which is manufactured by Squibb, this in no way detracts from its value as a statistical resume of the present status of fungus infections throughout the world. The papers by Dr. Selman Waksman on the antibacterial and antifungal antibiotics, the soil as a natural reservoir for human pathogenic fungi by Dr. Libero Ajello, the article on the possible approaches to treatment by Dr. J. Walter Wilson, and the reflections on the biology of ringworm infections by Dr. Albert M. Kligman are especially valuable to anyone in any field of medicine, and are well worth the volume alone.

This book should be in the library, and read by any laboratory workers interested in the growth or the study of fungi and fungus diseases. It is particularly valuable to the dermatologist.

Herbert S. Alden, M.D.

Wolstenholme, G. E. W.; Margaret P. Cameron and Cecilia M. O'Connor, **EXPERIMENTAL TUBERCULOSIS—BACILLUS AND HOST (Ciba Foundation Symposium)**, Little, Brown and Company, Boston, 1955, 396 pp., \$9.00.

This volume contains the proceedings of a symposium on "The Tubercle Bacillus and the Reactions of the Host Tissues" which was conducted in October 1955 in London under the Chairmanship of Dr. A. R. Rich. Twenty-two papers by authorities active in tuberculosis research in Denmark, England, France, Italy, Switzerland, and the United States are included.

It is apparent that interest is high in the chemical composition of the tubercle bacillus and the biologic activity of its constituents. Biochemical factors which might influence the fate of tubercle bacilli in tissues are discussed repeatedly; these factors include the activity of such compounds as spermine, lysozyme, basic peptides, adrenalin, and cortisone as well as the effects of oxygen deficiency and excess carbon dioxide and lactic acid. Additional evidence^{*} is presented that immunity and hypersensitivity in tuberculosis are separate entities. Combinations of tuberculoprotein and a wax-like substance extracted from tubercle bacilli give rise to typical tuberculin hypersensitivity when injected into guinea pigs, but immunity is not produced. Of special interest is the demonstration that the rapidly appearing and relatively extensive local tissue damage which follows intracutaneous BCG inoculation in tuberculin positive persons is greatly decreased if desensitization is first accomplished.

Free discussion follows each presentation and adds greatly to the excellence of the symposium. The value of this book rests with the fact that the unknowns in the interrelationship between tubercle bacillus and host are clearly delineated. Avenues for future investigation are therefore defined.

The book does not deal with the clinical aspects of tuberculosis. Its greatest usefulness will be as a reference source for those with specific interests in tuberculosis and infectious diseases in general.

Edward W. Hook, M.D.

abstracts by georgia authors



Combs, J. D., 490 Peachtree Street, N.E., Atlanta, Ga. "Psychoses Associated With Childbearing." *Dis. Nerv. System* 17:166-169 (May) 1956.

From 756 consecutive female psychiatric admission examinations at the Milledgeville State Hospital, 50 cases were observed in which psychoses were associated with childbearing. Of these 50 cases, 96 per cent were schizophrenic (10 per cent paranoid, 60 per cent catatonic, and 26 per cent hebephrenic), two per cent manic-depressive, manic), and two per cent organic (cerebral thrombosis).

The cases were considered from the psychosocial point of view in the following categories:

1. Attitude toward herself as a mother,
2. Attitude toward her husband,
3. Attitude toward her baby,
4. Attitude toward the home and family unit,
5. Attitude toward others outside the immediate family unit; and
6. Religious preoccupations.

The general manifestations of these cases do not seem to show any specific characteristics that are not seen in same diagnostic categories of the non-childbearing cases. The chief factors common to all concern the acceptance of the pregnancy, responsibility as a mother, and the social attitude toward childbearing. No specific modes of treatment were used that would not be used in the treatment of non-childbearing cases except precautions regarding pregnancy and postpartum obstetrical care. Sterilization seems indicated in severe cases, those in which psychotic episodes have been repetitious, and in instances where the maternal responsibilities are overwhelming.

Sadun, Elvio; Dorothy M. Melvin; M. M. Brooke; and C. H. Carter, C.D.C., Public Health Service, Atlanta, Ga. "A New Quantitative Approach to the Study of Anthelmintic Drugs, With an Evaluation of Piperazine Hexahydrate, Phthalylsulfathiazole, and RO 2-5655/3 in the Treatment of Enterobius Infection." *J. Pediat.* 48:754-762 (June) 1956.

Of 265 patients in a mental institution examined for the presence of *Enterobius vermicularis* infection 200, or 75 per cent, were found to be positive. The prevalence and intensity of infection were determined by six consecutive daily examinations of cellulose tape slide preparations.

A marked reduction in the prevalence and intensity of infection was observed following treatment with relatively high dosages of piperazine hexahydrate or phthalylsulfathiazole for 14 consecutive days. The effect of treatment with these drugs was still evident more than two months after therapy.

RO 2-5655/3, in the amounts used, was of very limited value in reducing the prevalence of infection. It produced, however, a moderate decrease in the intensity of infection.

Although spontaneous apparent cures were observed in the untreated controls, no marked changes in the intensity of infection occurred during the period of observation. The rate of spontaneous cure in the untreated controls and the degree of effectiveness of the drugs tested were somewhat related to the intensity of infection. These results suggest the use of a coefficient of infection in comparing the therapeutic effectiveness of various drugs.

Norman, Lois; A. W. Donaldson; and E. H. Sadun, C.D.C., Public Health Service, Atlanta, Ga. "The Flocculation Test With a Purified Antigen in the Diagnosis of Trichinosis in Humans." *J. Infect. Dis.* 98:172-176 (March-April) 1956.

Bentonite flocculation tests with an acid soluble protein fraction antigen and complement-fixation tests with a crude larval antigen gave comparable results in 1,331 human serums. The results of the two tests in 206 patients were compared with observations made on clinical grounds, and with other laboratory findings. A mutual relationship between serological findings and clinical trichinosis was observed.

On the basis of the results of this work and in view of ease of performance, it is believed that the flocculation test can be used instead of the complement-fixation test for the serological diagnosis of trichinosis in human beings.

Corpe, Raymond F., and Eugene C. Hwa, Battey State Hosp., Rome, Ga. "A Correlated Bronchographic and Histopathologic Study of Bronchial Disease in 216 Tuberculous Patients." *Am. Rev. Tuberc.* 73:681-689 (May) 1956.

In pathologic specimens revealing bronchiectasis, the pre-surgical bronchogram had clearly delineated the bronchiectasis with 76 per cent accuracy. In pathologic specimens failing to reveal bronchiectasis, 20 per cent of the bronchograms had been over-interpreted as showing bronchiectasis. In only 40 per cent of the bronchiectatic specimens was it possible to make a diagnosis of tuberculous bronchiectasis.

Areas of pneumonic and cavitary tuberculosis have the highest incidence of associated bronchiectasis following anti-tuberculous therapy. The incidence of post-bronchographic spread of tuberculosis was 1.2 per cent per bronchogram or 1.4 per cent per patient. There was a 10 per cent incidence of allergic reactions to iodized oil with only 1.5 per cent incidence of moderately severe reactions and no serious or fatal reactions. Oil retention hindered subsequent roentgenographic interpretation in 1.5 per cent of the patients.

With a short follow-up of an average of only 19 months per patient, it was surprising to see that only 11 per cent of the patients had difficulty with respect to their tuberculosis when they had had extensive disease and extensive bronchiectasis at the time of discharge.

Steadman, Henry E., Georgia Baptist Hosp., Atlanta, Ga. "Ruptured Interstitial Pregnancy Following Homolateral Salpingectomy." *Obst. & Gynec.* 7:572-575 (May) 1956.

The case presented is rather rare. The patient had salpingectomy for ruptured tubal pregnancy. The tube was removed close to the uterus. The patient later presented symptoms of a second ruptured ectopic tubal pregnancy. At operation the rupture was found to be of the interstitial portion of the tube previously removed. A small foetus was found floating in the peritoneal cavity. The opposite tube was normal. The patient later was delivered of two normal pregnancies.

The theories concerning etiology are discussed in the paper. Wedge excision of the entire interstitial portion of the tube at salpingectomy is advised to prevent such complications.

The treatment of interstitial pregnancy is discussed in detail.

Pruce, Arthur M., 1447 Peachtree Street, N.E., Atlanta, Ga. "Office Physical Therapy: What It Cannot Do." *South. M. J.* 49:497-499 (May) 1956.

The patient, the employer, the insurance carrier and the physician are interested in three things:

- (1) prompt treatment,
- (2) rapid cure, and
- (3) getting patient back on the job full time.

Physical therapy is the most common office procedure used in treating musculoskeletal problems.

Clinical records of 100 patients with industrial disability due to trauma are analyzed. In these 100 cases, physical therapy had been unsuccessful and invalidism had been prolonged due to either one or a combination of the following:

- (1) incomplete or faulty diagnosis,
- (2) inadequate therapy, and/or
- (3) premature termination of treatment.

The diagnostic deficit was due to:

- (1) inadequate neurological examination,
- (2) failure to evaluate muscle strength, and
- (3) overlooking the patient's emotional state.

The therapeutic deficit:

- (1) reliance on heat treatment with short wave diathermy or ultra sound as the sole therapy. Heat and help control pain and stiffness. It will not maintain or restore motion, nor prevent contractures, or develop muscular power,
- (2) specific prescription for therapeutic exercises should be based on findings as regards muscle strengths, tightness and contractures.

Treatment should be terminated when the patient is free of pain, when the functional range of joint motion has been restored, and when sufficient muscular strength has been gained for return to his full time employment.

Executive Committee of Council

The July meeting of the Executive Committee of Council was called to order by Chairman J. W. Chambers, 6:00 p.m., July 1, 1956.

Present were: Hal M. Davison, Atlanta; H. Dawson Allen, Jr., Milledgeville; David Henry Poer, Atlanta; J. W. Chambers, LaGrange; George R. Dillinger, Thomasville; Edgar Woody, Jr., Atlanta; Carl C. Aven, Marietta; Charles S. Jones, Atlanta; Bernard P. Wolff, Atlanta; Mr. Milton D. Krueger, and Mr. John F. Kiser, of the MAG Headquarters Office.

The minutes of the Executive Committee of Council meeting of June 2, 1956, Macon, were read and approved.

Health-Screening Tests Report—The Executive Committee approved a report of Health-Screening Tests presented by a committee of which T. A. Sappington, Thomaston, is chairman. It was voted to forward this report on to the Georgia Department of Education which had requested the information.

State Employees Physical Examination Committee Appointment—It was voted to appoint T. A. Sappington as a representative of the Medical Association of Georgia on a committee to study the question of physical examinations for Georgia State employees.

Milledgeville Hospital Study Commission Appointments—It was voted to appoint Rives Chalmers, Atlanta, and Hervey M. Cleckley, Augusta, as MAG representatives on the Milledgeville Hospital Study Commission created by the 1955-56 session of the Georgia General Assembly.

Bradley Center, Inc., of Columbus—A report on the Bradley Center, Inc., of Columbus presented by H. Dawson Allen, Jr., as compiled by the Muscogee County Medical Society, was received for information.

Rural Health Committee—Mr. Kiser presented a report of the June 10, 1956, meeting of the Rural Health Committee. Request for the Rural Health Committee Chairman to attend the AMA Rural Health meeting October 19-20, 1956, Lafayette, Indiana, meeting was approved, with expenses to be met by 1956 budgeted committee appropriation.

Hospital Care Study Commission Activity—Mr. Kiser presented information in regard to the Hospital Care Study Commission and described the survey now being sent out to 950 selected physicians in the state.

Medical Practice Act Committee Report—Dr. Poer discussed the June 13, 1956, meeting of the Liaison Committee to study revision of the Georgia Medical Practice Act. The committee plans another meeting in the end of July.

Savannah Annual Session Plans—Dr. Poer and Mr. Krueger discussed plans for the 1957 Annual Session to be held in Savannah. Dr. Poer asked all members of the Executive Committee for their comments and suggestions in the next few weeks in regard to this meeting. He pointed out that the Council Committee on Annual Sessions meeting will be held July 14 at the DeSoto Hotel with officers of the Georgia Medical Society to begin plans for a 1957 meeting.

Council Building Committee Report—George R. Dillinger, Thomasville, Chairman of the Finance Committee, discussed the MAG budget. He presented a balance sheet which showed the financial condition of the Association as of July 1.

Dr. Poer and Dr. Dillinger discussed the budget as far as it concerned the Annual Session. The price of booths for the Savannah meeting was discussed, and the matter was referred to the Annual Session Committee of Council. Dr. Dillinger also informed the Executive Committee that the Finance Committee is going ahead with plans to acquire new bookkeeping equipment at a cost of approximately \$1,000.00 as discussed at a previous Council meeting subject to Finance Committee approval.

Legal Counsel Committee Report—Dr. Davison, Chairman of the Legal Counsel Committee, discussed the meeting held earlier the same afternoon. The committee discussed Mr. Dunaway's report of the State Medical Society Legal Counsel meeting at Chicago sponsored by the AMA in April. Dr. Davison also pointed out that the committee had discussed taking action in regard to the House of Delegates directive concerning the securing of legal counsel to study the status of medicine in Georgia particularly in regard to the corporate practice of medicine. Dr. Poer was appointed to make preliminary investigations in order to carry out this directive. It was felt that the members of the committee would talk by telephone following Dr. Poer's investigations within a week or two.

History and Vital Statistics Committee Appointments—Dr. Davison informed the committee that he had appointed Carl C. Aven, Herbert Alden, and Cyrus Strickler, Jr., all of Atlanta, to serve on a committee to study the report of the History and Vital Statistics Committee as requested by that committee.

Georgia Plan Insurance Progress—Mr. Krueger presented information from the Committee on Insurance and Economics in regard to revision of "The Georgia Plan." He informed the Executive Committee that plans are now complete, and the Headquarters Office is ready to go ahead with printing of the new fee schedule, notifying the companies and signing up members of the Association again. It was voted to comply with the requests of the Committee on Insurance and Economics.

Medical Defense Privileges—It was voted to announce the recent change in regard to medical defense privileges in the *Journal* rather than mailing a letter to every member of the Association.

Lectureship Committee Appointments—After discussion it was decided to leave the matter of the selection of this Committee to the Chairman and the Secretary.

Workmen's Compensation Study Committee—Several suggestions were made for appointments to this committee, and Dr. Chambers, Chairman, informed the Executive Committee that he would make these appointments in the near future.

Medical Education Committee—Dr. Poer discussed the recent report of the Council on Medical Service at the 1956 June AMA meeting. He also discussed the formation of a Liaison Committee to work with Emory University School of Medicine and the Medical College of Georgia. He suggested that these be two sub-committees of the Medical Education Committee.

New Business—A code of cooperation between hospitals and the Medical Association in West Virginia was referred to the Council Legal Counsel Committee.

ANNOUNCEMENTS

American Board of Obstetrics and Gynecology Applications for Certification—Applications for the 1957 Part I examinations are now being accepted; deadline for receipt of application is Oct. 1, 1956. Current bulletins outlining present requirements may be obtained by writing: Robert L. Faulkner, M.D., American Board of OB and GYN, 2105 Adelbert Road, Cleveland 6, Ohio.

First Inter-American Conference on Occupational Medicine and Toxicology—Miami, Fla., September 3 to 7, 1956. The University of Miami School of Medicine will sponsor the conference jointly with the University of Havana School of Medicine; the official language of the program will be Spanish. For further information, write to Dr. Homer F. Marsh, Dean of the School of Medicine of the University of Miami and General Chairman of the meeting.

1957 Prize Essay Contest—The Council on Undergraduate Medical Education of the American College of Chest Physicians offers three cash awards (\$500, \$300, and \$200) to be given for the best contributions prepared by undergraduate medical students on any phase in the diagnosis and treatment of chest diseases (heart and/or lungs). For information and application form, write to the Executive Director, American College of Chest Physicians, 112 East Chestnut St., Chicago 11, Ill.

Postgraduate Courses on Diseases of the Chest—Hotel Knickerbocker, Chicago, Ill., October 15-19, 1956; and Park-Sheraton Hotel, New York City, November 12-16, 1956. Tuition for each course is \$75. Further information may be obtained from the Executive Director, American College of Chest Physicians, 112 East Chestnut St., Chicago 11, Ill.

American College of Physicians Postgraduate Courses—The following courses will be offered in the fall of 1956: Recent Advances in Cardiovascular Disease, Clinical Neurology, Internal Medicine, Recent Advances in Internal Medicine, Selected Problems in Internal Medicine, Gastroenterology, Electrocardiography, Pathologic Physiology of the Blood Dyscrasias. For information as to dates and location of each course, write to The American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa.

American Medical Writers' Association Meeting—Hotel Morrison, Chicago, Ill., September 28-29, 1956. Speakers include Dr. Dwight Murray, AMA President; Dr. Paul Dudley White, Boston; Dr. Richard M. Hewitt, Alton Blakeslee, Dr. Morris Fishbein, Dr. Austin Smith, etc. For further details, write to Dr. Harold Swanberg, Secretary, 209-224 W. C. U. Building, Quincy, Ill.

American Rhinologic Society Annual Meeting—Illinois Masonic Hospital, Chicago, Ill., October 9-13, 1956. For information, write to Mrs. Mabel Campbell, Corresponding Secretary, 834 Wellington Ave., Chicago 14, Ill.

Fiske Essay on Infertility—The Caleb Fiske Prize of the Rhode Island Medical Society will be given this year for the best dissertation on "The Present Day Treatment for Infertility." The paper should be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of \$350 is offered. Essays must be submitted by January 1, 1957. For complete information, write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis St., Providence 3, R. I.

Eighth Annual Meeting and Scientific Sessions of the Georgia Heart Association—General Oglethorpe Hotel, Savannah, September 14 and 15, 1956. No registration fee for physicians, interns and medical students. Reservations should be made directly with the General Oglethorpe Hotel, Savannah. The meeting is approved for Category I credit by the American Academy of General Practice. Speakers include the following: Robert Glover, M.D., Thoracic and Cardiovascular Research Laboratory, Presbyterian Hospital, Philadelphia; Steward Wolf, M.D., Professor and Head of the Dept. of Medicine, University of Oklahoma School of Medicine; William B. Schwartz, M.D., Assistant Professor of Medicine, Tufts College Medical School; Eugene A. Stead, Jr., M.D., Professor of Medicine, Duke University School of Medicine; and Noble O. Fowler, Assistant Professor of Medicine, Emory University School of Medicine. A panel, composed of all the visiting speakers, will be held as the last event of the session; Charles F.

Stone, Jr., will act as moderator. Please send any questions that may occur to you in advance to Dr. Stone, 384 Peachtree St., N. E., Atlanta 8, Ga. A box will also be placed in the meeting hall to receive questions.

Georgia Tuberculosis Association and Georgia Trudeau Society Annual Meeting—Rome, Ga., September 21 and 22, 1956. The theme of the meeting is "The Patient, the Hospital, and the Community." For information, contact the Georgia Tuberculosis Association, 33 Pryor Street, N. E., Atlanta 3, Ga.

International College of Surgeons Annual Congress—Palmer House, Chicago, Ill., September 9-13, 1956. For specific information about the program write to the Secretariat, International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, Ill.

Mississippi Valley Medical Society Meeting—Hotel Morrison, Chicago, Ill., September 26, 27, and 28, 1956. Details may be obtained from the Secretary, Harold Swanberg, M.D., 209-224 W. C. U. Building, Quincy, Ill.

DEATHS

Whereas, the death of Dr. FRANK A. DANIEL, April 12, 1956, brought sorrow to the many patients and friends who loved, trusted, and admired him, and

Whereas, his death will be a loss to the people of his community;

Be It Resolved, That the members of the Thomas-Brooks Medical Society feel the loss of a fellow member;

Be It Further Resolved, That a copy be sent to the family of Dr. Daniel, and that a copy be sent to the *Journal of the Medical Association of Georgia*.

HOWARD CLIFTON DERRICK, SR., Oglethorpe, died on June 8, 1956, after a long illness. He was made a Life Member of the Medical Association of Georgia in 1952 and was 78 years old at the time of his death.

Dr. Derrick was an alumnus of the Emory University School of Medicine, class of 1902, and began practicing in Oglethorpe immediately after graduation. He was a member of the Third District Medical Society and the Peach Belt Medical Society. He was also a 32nd degree Mason, a member of the Botsford Lutheran

(Deaths)

Church, and a former member of the Macon County School Board.

Surviving Dr. Derrick are his wife, the former Miss Elvie Jennings; a daughter, Mrs. Pauline Wiggins; four sons, H. C. Derrick, Jr., M.D., Lafayette; C. Jennings Derrick, West Palm Beach, Fla.; Jesse B. Derrick, Montezuma, and W. Steward Derrick, Atlanta

Funeral services were held on June 10th at the Oglethorpe Lutheran Church, with burial in the Oglethorpe Cemetery.

C. HALL FARMER, Macon, died on June 23, 1956, at his home in Macon.

A life-long resident of Macon, he attended public schools there and graduated from Mercer University and Emory University School of Medicine. He was a diplomate of the American Board of Pediatrics, a fellow and past state chairman of the American Academy of Pediatrics, and past president of both the Georgia and Macon Pediatrics Societies.

Dr. Farmer was a member of the Idle Hour Country Club, the Elks, YMCA, American Legion and the Shrine. He was an elder and charter member of Vineville Presbyterian Church.

Dr. Farmer is survived by his wife, the former Miss Eugenia Lowe; a daughter, Mrs. William T. Barnett, Macon; a stepson, Oscar Spivey, M.D., Macon; a brother, Frampton Farmer, M.D., Macon; and a niece, Mrs. Sam Popejoy, Macon.

Funeral services were held in Memorial Chapel on June 24th, with burial in Riverside Cemetery. Physicians serving as pallbearers were Charles Rumble, Samuel E. Patton, and Harold Atkinson. Elders and deacons of the Vineville Presbyterian Church and members of the Bibb County Medical Society formed an honorary escort.

Whereas, the death of Dr. LEIGHTON A. SMITH, May 7, 1956, has resulted in a severe loss to his many patients and friends and has brought sorrow to the people who loved, trusted and honored him.

Be It Resolved, That Brooks County has lost a most valued and efficient physician and surgeon, and that the Thomas-Brooks Medical Society, which he was instrumental in forming, has lost a guiding personality who was a friend to and a co-worker

with each member and whose presence will be missed always; and

Be It Further Resolved, That a copy of these resolutions be put in the minutes of the Thomas-Brooks Medical Society, a copy be sent to the family of Dr. Smith, and a copy be sent to the *Quitman Free Press* and the *Journal of the Medical Association of Georgia*.

SOCIETIES

The BIBB COUNTY MEDICAL SOCIETY held its annual picnic on July 12th at Dr. Samuel Patton's pond. Serving with Dr. Patton on the Picnic Committee were R. W. Edensfield, W. Earl Lewis, and Robert E. Cato. Refreshments were served at 5:30 and barbecue at 6:30. All members and their wives, the Macon Hospital house staff and their wives, and medical students were invited.

COBB COUNTY MEDICAL SOCIETY has announced plans for a three-day Cavalcade of Medicine which will take place at the Larry Bell Auditorium, November 11, 12, and 13, 1956. There will be a large collection of displays, x-rays, tissues, models, movies, equipment, etc., gathered from all over Georgia and other parts of the country. E. P. Inglis and E. S. Marks, Marietta, are co-chairmen of the Cavalcade, and Remer Y. Clark and Robert Coggins, Marietta, are chairmen of displays. The exhibition will be open to the general public.

At the June meeting of the MUSCOGEE COUNTY MEDICAL SOCIETY, Edgar R. Pund, president of the Medical College of Georgia, was the principal speaker. His subject was "Pathogenesis of Carcinoma."

PERSONALS

First District

George Dane, formerly of Duval Medical Center, Jacksonville, Fla., began his practice of medicine in Metter on July 1st.

A new 15-bed facility for the care of chronic and semi-invalid patients is being set up at Telfair Hospital. Serving on an advisory committee to assist the managing board of the hospital are JOHN C. WITHINGTON, chairman; WILLIAM H. FULMER, ANNE HOPKINS, and LAWRENCE LEE, JR., all of Savannah.

Second District

E. M. FLOWERS, Tifton, announces the association with him in

the practice of medicine of Hewlett Edwin Aderholt, formerly of Macon, at 211 East 12th Street. Dr. Aderholt is a native of Jefferson and a graduate of the University of Georgia and the Medical College of Georgia. He served his internship and residency at Macon City Hospital. Dr. Aderholt has just completed a year as chief surgical resident there.

Martin Bailey, Cairo, announces the opening of his office for the general practice of medicine in Cairo. A native of Harlem, Dr. Bailey is a graduate of the University of Georgia and the Medical College of Georgia. He interned at Athens General Hospital.

BENJAMIN C. WILLS, Savannah, announces the association with him in the practice of neurology and psychiatry of Henry A. Brandt, formerly head of the department of neurology and psychiatry at the VA hospital in Augusta. Their offices are located at 210 East Gaston Street. Dr. Brandt obtained his medical education at the Medical College of South Carolina and the Medical College of Alabama. He held fellowships in neurology and psychiatry from 1949 to 1952 at the University of Minnesota. He served in the U. S. Air Force from 1952 through 1954. He was certified by the American Board of Psychiatry and Neurology in 1955.

Third District

WILLIS P. JORDAN, JR., Columbus, talked to the Lions Club recently about the status of City Hospital in Columbus. He said that the present administrative setup is preferable to the changes suggested recently by a governmental survey team. Dr. Jordan, City Hospital chief of staff, told the Lions that last year the hospital had 10,000 bed patients and that in the out-patient section there were 25,000 patients. It was announced also that as of January 1, 1957, the name will be changed from "City Hospital" to "Columbus Medical Center."

Fourth District

Norman Gardner, Thomaston, has entered private practice in Thomaston after having served as senior resident in medicine at Macon Hospital for the past year. Dr. Gardner is a native of Madison.

Fifth District

CARL C. AVEN, Atlanta, was

elected Historian of the American College of Chest Physicians for 1956-57 at its 22nd Annual Meeting held in Chicago, June 6-10. OSLER A. ABBOTT is the governor of the college for Georgia.

J. GORDON BARROW, Atlanta, has been made director of the Division of Heart Disease Control for the Georgia Department of Public Health. Dr. Barrow, a native Atlantan, will direct the division on a part-time basis. He formerly served as director of the cardiac programs in Fulton and DeKalb Counties.

Normal H. Blass announces the opening of his office on July 2nd for the practice of obstetrics and gynecology at 102 North Church Street, East Point. He will head the East Point Obstetrical Clinic. Born in New York City, Dr. Blass is a graduate of New York University and the Chicago Medical School. He interned in Chicago and has been resident at Chicago Lying-In Hospital and Grady Memorial Hospital, Atlanta. He is on the teaching staff of Emory University School of Medicine.

Accompanying Dr. and Mrs. WALKER L. CURTIS, College Park, on their trip to Chicago for the AMA meeting in June were their son and daughter, Lewis and Memye. Memye has just graduated with honors from Agnes Scott College.

WILLIAM G. HAMM, Atlanta, was a speaker at the recent Third Annual Mountaintop Medical Assembly in Waynesville, N. C.

ARTHUR MERRILL, Atlanta, addressed the newly formed Georgia Chapter of the National Nephrosis Foundation, Inc., at a recent meeting held at the Academy of Medicine. Dr. Merrill spoke on the control, with newly developed antibiotics, of infections to which nephrosis victims are susceptible.

Sixth District

BENJAMIN BASHINSKI, Macon, announces the opening of his office in Macon; he is associated with ROBERT W. McALLISTER in the practice of urology. A native of Macon, Dr. Bashinski is a graduate of Mercersburg Academy, in Pennsylvania, and Tulane University. He interned at Charity Hospital in New Orleans. Dr. Bashinski is the son of the late BENJAMIN BASHINSKI, SR., Macon pediatrician.

FRANK CAREY and ZACK E. GREER, Macon, were honored recently for their service to the Bibb County Tuberculosis Association. Dr. Carey was district health officer until his retirement in July, and Dr. Greer is the former assistant health officer and plans to leave Macon soon. Speaker for the meeting was SAMUEL E. PATTON, who reported on the activities of the National TB Association Convention in New York.

L. A. Stoddard, Augusta, professor of pathology at the Medical College of Georgia, addressed the medical staff of the Veterans Administration Hospital, Dublin, on June 26th. His topic was "Carcinogenesis: Cancer in Situ."

Robert M. Wynne, Macon, announces the opening of his office at 2305 Ingleside Avenue in Macon. Dr. Wynne has been assistant resident at Macon Hospital for the past year.

Dr. and Mrs. WALTER P. BARNES, JR., Macon have a new daughter, born on July 5th.

Seventh District

REMER Y. CLARK, JR., Marietta, plans to build a new doctors' office building at 1422 Cherokee Street in Marietta.

W. H. LUCAS, JR., Cedartown, has returned to his hometown from Atlanta where he has just completed a year's internship at St. Joseph's Infirmary. He is now associated in practice with his father at the W. H. Lucas Clinic.

E. A. MUSARRA, Marietta, was elected president of the Kennestone Hospital medical staff in June; B. D. BURLEIGH is vice-president.

PAUL B. REASER, Dalton, has been appointed medical examiner for Whitfield County.

Eighth District

E. A. MASON, formerly in practice with JOSEPH M. JACKSON and W. R. McCOY in Folkston, has gone to Williamsburg, Va., where he will serve on the staff of the Williamsburg Hospital.

Ninth District

A reception was held on July 1st for Dr. and Mrs. W. J. HUTCHINS, Buford, at the First Methodist Church in Buford. Dr. Hutchins is celebrating his 47th year in the practice of medicine, and 43 of those

years have been spent in Buford. Dr. Hutchins estimates that he has delivered more than 6,000 babies.

F. M. McELHANNON, Winder, closed his office in Winder on June 30th to enter surgical residency at Thayer General Hospital, Nashville, Tenn.

BEN NALLEY, Gainesville, who has been in training at Johns Hopkins University for the past three years, has resumed his practice at Gainesville. Dr. Nalley, specializing in obstetrics and gynecology, is associated with JOHN K. BURNS, JR.

Tenth District

Joe Bennett, a native of Waycross, practiced in the office of SAM DEFRESE in Monroe from July 22 through August 5 while Dr. Defreese was on Reserve duty at Fort Stewart. Dr. Bennett is a graduate of the Medical College of Georgia and practiced for many years in New York.

Four new members have been added to the faculty of the Medical College of Georgia. They are George Williams Smith, M.D., associate professor of surgery and chief of neurosurgery; Floyd Edward Bliven, Jr., M.D., assistant professor of surgery and chief of orthopedics; Edwin Leland Brackney, M.D., assistant professor of surgery; and Boyd Dudley Sisson, Ph.D., instructor in clinical psychology.

EDGAR R. PUND, Augusta, has announced that \$100,000 will be given by the National Foundation for Infantile Paralysis to pay for respiratory equipment in the polio section of the Eugene Talmadge Memorial Hospital. To date, almost \$80,000 has already been given.

JACK E. BELL, Augusta, announces the association with him in the practice of pediatrics of CHARLES HAROLD WATSON. Dr. Watson is a native of Graymont; he attended Emory-at-Oxford and the University of Georgia. Following his graduation from the Medical College of Georgia in 1952, he interned in pediatrics at Duke Hospital in Durham. He was assistant in pediatrics at University Hospital in Augusta in 1953-54; in 1954-55, he held a fellowship in pediatric cardiology from the Georgia Heart Association at University Hospital; and in 1955-56 he served as chief resident in pediatrics.

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The JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and Copyrighted, 1956, by the Medical Association of Georgia, 878 West Peachtree Street, N.E., Atlanta 9, Georgia. Published monthly under the direction of the Council of the Association. Subscription rates: \$5 per year; \$1 per single copy. Entered as second-class mail at the post office at Atlanta, Georgia, under the Act of March 3, 1879. Accepted for mailing for the general rate of postage provided for in Section 1103, Act of October 6, 1917, authorized November 14, 1928.

Journal OF THE MEDICAL ASSOCIATION OF GEORGIA

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COVER

Pictured this month is the famous Greek physician Hippocrates, called the "Father of Medicine." Born in 460 B.C., he extracted from his pupils the oath now known as the Hippocratic Oath. Photo by Ted F. Leigh, M.D.

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Dependents' Medical Care Act

ON JUNE 7, 1956, Public Law 569, 84th Congress, was signed by the President, thereby authorizing the federal government to assume responsibility for the care of dependents of members of the uniformed services. This Dependents' Medical Care Law provides for the Secretary of Defense to arrange for medical *inpatient* care, in civilian medical facilities, for wives and children (and dependents) of men on active duty in the uniformed services. The law further provides for the Secretary of Defense to arrange a plan or plans to pay physicians and to pay hospitals for this care.

A Southeastern Regional Conference for state medical associations was held in Atlanta with the Department of Defense Task Group on Dependent Medical Care. Objectives of the Task Group were to present a plan in broad outline that would meet the constitutional responsibility of the executive branch of the federal government and would also have the approval and endorsement of the physicians providing the medical services required.

The plan has the following features:

(1) Regulations which define who is eligible for civilian medical care and how they shall be identified; nature and extent of medical benefits authorized.

(2) Provision for a *full service* plan based on a negotiated schedule of fair and reasonable fees to be set by the physicians themselves (on a statewide basis, it is hoped). The fees agreed upon would provide full service in a hospital for a medical condition and the fees for treatment of a bodily injury or a medical condition would include physicians' and surgeons' services prior to hospitalization, and for normal after-care.

(3) Dependents using civilian facilities should receive medical care comparable to that available in military hospitals. This would rule out the possibility of re-

quiring dependents to make any expenditure other than those required by this law.

(4) Provision for a "fiscal agent" to act as a contracting agency, such as Blue Shield, a commercial insurance company, or the state medical association itself, to act as a "go between" for the physicians and the Department of Defense. This agent would negotiate for the state medical association with the Department of Defense on physicians' participation in the plan, pay physicians' bills promptly, arbitrate disputes, submit for payment to the Department of Defense composite bills for services rendered, and compile statistics needed for annual Department of Defense report to the Congress.

Civilian medical care for dependents who have not had access to military hospitals is but one of a number of steps taken to increase military career appeal. National security requires Armed Forces of nearly three million men. Defense expenditures now total about 36 billion, of which 16 billion is pay for personnel. Every year one-third of all military personnel, or one million men, leave the services and must be replaced. This rapid turnover is unbelievably expensive, not only in terms of combat readiness but also in terms of dollars. As any other employer would do, the Department of Defense has been trying to stop this expensive personnel turnover by a legislative campaign to improve career incentives. There is nothing new about the concept: medical care for military dependents has been a traditional right and benefit since 1818. The postwar size of our active duty Armed Forces has made this medical care uneven. Where dependents live near military hospitals, there is no problem. But it is estimated that 40 per cent of the two million dependents have no access to military medical facilities. It is this 40 per cent, living all over the United States, that we are concerned with.

Questions and Answers Concerning Public Law 569

Q. Please clarify how far the choice between civilian and military facilities extends.

A. Dependents of active duty personnel, residing with their sponsor on or near a military installation will be advised as to their source of care. Such dependents who do not live with their sponsors (with the exception which follows) are free to elect between civilian and military facilities. The exception applies to obstetric and maternity care for those who reside reasonably close to a facility of the uniformed service. This specific exception is due to the stated desire for optimum use of service facilities. It should be remembered that the law is so written to permit the secretaries of the various services to impose further restrictions on free choice.

Q. What assurance can be offered that medical care fees and hospital payment will be related to changes in "cost of living" standards?

A. Schedules of fees adopted are subject to renegotiation. According to information received, the schedules will be subject to review and revision from time to time, probably on a yearly basis.

Q. Is the definition of chronic diseases clear?

A. Not entirely. The Defense Department Task Group indicated that it would give further consideration to Section 103 (h) (6) with the possibility of revising it to read:

"Chronic Diseases. This term shall be construed to include conditions and disabilities of long continued duration. (This shall not include acute exacerbations or acute complications of such conditions and disabilities wherein active and definitive medical or surgical treatment is required.)"

Q. When "fair and reasonable fees" are mentioned, is the phrase used in the same sense as "prevailing fees" in any geographical location?

A. Captain Noel was not certain whether there is a relationship between "fair and reasonable fees" and "prevailing fees." It was his opinion however that the profession in the various localities would attempt to establish fees which would be acceptable to the majority of physicians.

Q. Who sets the local fee schedule?

A. Fee schedules are to be subject to negotiation between the medical society and the Department of Defense. That Department hopes that these fee schedules will be on a state or on a district basis geographically.

Q. Please clarify the statement that the present Blue Cross-Blue Shield fee schedules are not satisfactory for the suggested program.

A. The Blue Cross—Blue Shield fee schedules vary in many instances, based on the income of the insured. It has been stated that such schedules are substandard or less than the fees normally charged.

Q. I do not understand the \$25.00 payment for hospitalization.

A. Since the payment for medical care in most instances is limited to that which is incident to hospitalization, the \$25.00 deductible is imposed as a deterrent from unnecessary hospitalization.

Q. Is it or is it not intended that the fees established in the local fee table shall be the full cost of professional medical services in a given instance?

A. Yes, except for such exceptions as noted in the answer to question following.

Q. Does the service member have any financial responsibility to the plan other than the per diem?

A. Not insofar as the majority of authorized care is concerned. The law provides that the charge is \$1.75 per day in military facilities is to be made for subsistence during in-hospital care. This same responsibility applies in civilian facilities, if \$1.75 per day results in a contribution equal to or greater than \$25.00. Other possibilities for financial contribution are: (1) the use of private hospital room; (2) utilization of private duty nursing, and (3) authorized treatment of non-hospitalized bodily injuries (including allowances for laboratory tests, etc.) in excess of \$15.00, all of which must be certified as medically necessary by the attending physician.

Q. Is it true that P. L. 569 does not contemplate full payment of medical care?

A. The legislative history of the Act is such as to assume that Congress intended full coverage. It has been stated that there were those who felt the law did not require full payment of the cost of medical services. (This explanation distinguishes between the so-called "intent" and the "express requirement" of the law.)

Q. Will a dependent living on a military post where facilities are available have free choice between military and civilian facilities?

A. Not if military facilities are determined by the proper medical authority to be adequate. It is possible that certain military facilities will not be able to care for all of the dependents living on or near the post.

Q. Where Blue Shield is not controlled by the local society and not under insurance commission, who is to control the plan in its negotiations if selected as agent between medical society and Department of Defense?

A. It is up to the medical association to say who will act as the fiscal agent. It is presumed that any agency selected will act in the premises as its charter and bylaws demand. A fiscal agency can bargain only to the extent of its authority. If a Blue Shield plan is not satisfactory to the medical profession it could not, therefore, act as its fiscal agent.

Q. Just what services will the private physician be permitted to render?

A. Any authorized care requiring hospitalization and certain services in his office which will be spelled out later by regulation. (It is anticipated that this would be covered specifically by the regulations and the profession will be informed.)

Q. If a dependent has private insurance, will the government program be supplementary? In other words, will the dependent be required to use his private insurance first before the government plan steps in.

A. The government program will not be supplementary to any private insurance program.

Q. Are osteopaths excluded or included as Draft No. 6 now stands from performing services under P. L. 569 (a) in 37 states; (b) in 11 states; (c) in all states?

A. Osteopaths are not excluded in all states. According to the best estimates now available it appears that osteopaths are eligible to participate in only 11 states.

Q. Will VA hospitals be interpreted to be uniformed service facilities?

A. No.

Q. What are usual and reasonable commuting distances? If to service facilities what will be the breaking point between travel plus service costs and local civilian care costs?

A. This will be left to local determination. Draft No. 6 includes the following statement: "...consideration shall be given to normal commuting time, distance, and unusual geographic and transportation factors, such as toll bridges or ferries, which would increase unreasonably the time and expense of travel. Application of these terms to local conditions in these prescribed areas shall be the responsibility of the local hospital and area commanders."

Q. What about the 60% where service facilities are inadequate?

A. These individuals will presumably be taken care of in civilian facilities.

Q. How will abuse of hospital service in civilian facilities be prevented when personnel on detached service desire medical care for their dependents?

A. Geographic location and \$25.00 deductible were given as examples of deterrents.

Q. Should not a provision be: "Payment for professional services shall be made only to the individual rendering the service."

A. This would appear to be administratively impossible. Draft No. 6 (Section 507 b. (1) (E) and (2) (C)) indicates that payment of bills will be done through the contracting agency.

Q. Why is 365 days hospitalization authorized for each admission if the intention is not to care for chronic cases?

A. This time limit was placed in the bill by the Congress to cover, it is believed, such conditions as severe bodily injuries resulting from automobile or plane accidents, poliomyelitis, etc.

Q. Relative to the 365 days for each admission—can a patient be discharged for one or two days and return for another 365 days?

A. Yes, according to the law which states: "...up to 365 days for each admission..." (Section 201 (a) (1))

Q. Would the Department of Defense attempt to decrease the physician personnel requirements by encouraging utilization of civilian facilities; i.e., tend to reduce Doctor Draft requirements?

A. It is believed that the Doctor Draft will end soon. Facilities of the uniformed services are not to be increased. The Defense Department does not contemplate requesting the extension of the Doctor Draft Law.

Q. What is an example of an "elective" medical service?

A. This has been properly defined as surgery desired by the patient rather than the physician; in other words, elective surgery in this Act is different from the term as commonly used by the medical profession. As a practical matter, cosmetic surgery will be about the only one which will fall under the heading of "elective."

Q. Is there any plan to differentiate between (a) dependents of active duty personnel, and (b) dependents of retired or deceased personnel?

A. Dependents of active duty personnel are the only ones eligible for treatment in civilian facilities. Dependents of retired or deceased personnel must be treated in military facilities, provided they are available.

Q. What about the dependent who is under 21, is married, but the husband is unable to support her, for example, is still going to school?

A. The law specifies (Section 102 (a) (E)) "...unmarried legitimate child..." Those who become married are removed from the dependent category regardless of age.

Q. What about the dependent receiving medical care, as in a pregnancy, whose husband returns to civilian or reserve status during the course of treatment?

A. The proposed regulations anticipate provisions to accommodate situations where military personnel are transferred. Moreover, the dependent identification cards anticipate expiration dates. Those cases not covered by regulation would be considered on an individual basis.

Progress in Cancer Diagnosis

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THE MOST RECENT statistics reveal an overall improvement in cancer cure rates from 15 per cent to about 40 per cent over the past 10 years. There are many reasons for this improvement in cure rates, and in considering them we must at once profess our lack of knowledge in the detailed mechanisms of their benefit.

In the past decade, improvements in techniques of administration of ionizing radiation have centered about use of super-voltage and super-super-voltage Roentgen therapy externally as well as development and increasing use of various man-made radioactive isotopes for both external and interstitial irradiation. These developments probably have increased the so-called cure rate in cancer and most assuredly have decreased the morbidity and perhaps the mortality from ionizing radiation; however, probably the greatest improvement in radiotherapy has come from the radiotherapist's full utilization of adjunctive or supportive measures during and following exposure to radiations. Among these can be placed the increased use of better antibiotics, hormones, blood transfusions, vitamins, and maintaining nutrition and electrolyte balance as well as using possibly-effective anti-cancer chemotherapy in conjunction with the radiation.

The same things which allow the radiotherapist to achieve better results also have allowed the surgeon to extend resection to broader fields with much greater safety for the patient, pre-operative preparation is better, and the post-operative problems are much better understood and solved. With the patient better prepared, and with improving anaesthesiology and support during the operative procedure, the area of resection is almost limitless. The actual philosophy in extending surgical resective limits, or even radical radiotherapy for that matter, must remain an individual problem and is beyond the scope of this communication.

Unfortunately, as yet we have neither discovered nor developed any hormonal or chemotherapeutic method which has resulted in any cures for cancer. Palliation has been afforded in a great many instances, but there has been no *bona fide* cure. To many physicians and laymen alike, it may seem strange that the great amount of time, money, and effort directed to the problem of malignant diseases over the past 10-15 years has been productive of what appears to be so little. Those physicians and laymen must be consoled with the fact that while we have in this search made enormous additions to our knowledge of biology, pharmacology, biophysics, and other adjunctive fields and have yet not found a cure in a simple form, the answer may be just over the horizon; and we may have such an answer before this paper goes to press. It must be stressed that such a hope is far too optimistic to be commensurate with the facts. We must realize that the task is arduous, the field enormous, the stimulus relatively recent, and progress slow.

We are hampered likewise by the absence of any kind of laboratory test (other than cytohistology) which is simple enough and yet dependable enough to give us the diagnosis of cancer at a more practical time in the life history of the tumor. With this goal thus limited to the future, the American Cancer Society and others initiated about 10 or more years ago a strenuous campaign aimed at the early diagnosis of cancer so that therapy could be instituted as soon as possible in the life history of the cancer. The value of this expensive program has been questioned by some, but one cannot ignore the fact that since it was begun the over-all cure rate has increased. The logic must be admitted thereby, that the earlier a correct diagnosis is made and the earlier the best appropriate therapy is instituted, the higher the cure rate will be.

Medical and lay education of the public is the only

means we have today of improving the earlier diagnosis of cancer where the patient, of his own volition, with or without symptoms, comes into the physician's office. After medical attention has been sought by the patient any ignorance or culpability for delay in diagnosis and treatment must be assumed by the physician alone in a very substantial percentage of cases.

Pack and Gallo¹ found a delay of more than three months due to the patient alone in 44.3 per cent of cases, delay due to the physician alone in 17 per cent, and delay due to joint fault in 18 per cent. Another survey² (1948) 10 years later revealed a gratifying decrease in the (1) over-all delay (32.5 per cent no delay in 1948 versus 20.7 per cent in 1938) and (2) delay due to the patient (down to 31.2 per cent). On the contrary, the percentage of cases delayed due to the physician alone had unfortunately risen to 23.4 per cent. Moreover, Robbins, et al³, in a study of physician-patients with cancer found with disappointment that "physicians (1) are not sufficiently concerned about the early diagnosis of such diseases in their own persons, and (2) permit an unjustifiable delay before curative treatment is started, and (3) choose for their initial consultant a physician whose culpability for delay is approximately as great as that for general practitioners."

Because this failure in instituting proper treatment is so frequent, it behooves all of us, as physicians, to do our part to prevent delay as the layman-patient has apparently improved his share.

As succinctly as possible I should like to outline some of the more important symptoms and signs of cancer and emphasize again that our goal is to find cancer in its earliest stage when it is undeniably easiest to cure. Many of these signs and symptoms may seem very obvious to many physicians, yet every day errors in delay are made in patients with just such findings; on the other hand, we should all realize that in cancer there are no "pathognomonic signs" particularly in the stages we are interested in discovering the tumor.

Skin

This group of lesions has in general a high curability rate; the outstanding exception to this fact is the enigma, melanoma. The only field of preventive measures in melanoma may be excision before puberty of any suspicious lesion and after puberty of any junctional nevi on the palms, soles, or about the genitalia. The practicality of such a course varies; otherwise, we are faced with the alternative of adequate excision of any nevus which undergoes clinical change and submission of the material for pathologic study.

Bone

As skin cancer is common, malignant bone and cartilage tumors are rare; as the cure rate of skin cancer is high, that of bone cancer is low. How much of the low cure rate is due to delay in diagnosis is debatable; the fact remains that most malignant tumors of bone give symptoms from three to nine months (and often as long as two or more years) before definitive treatment is undertaken. The majority of this time is not taken up by the patient, for the pain in the long bones occurring particularly at night is severe enough to make the patient seek medical aid relatively soon after it appears.

These tumors are detected and diagnosed with great accuracy by X-ray examination. Here, incisional or excisional biopsy should be undertaken only by the physician who is prepared to give definitive therapy for the lesion.

Central Nervous System

Intracranial and spinal cord tumors produce amazingly characteristic clinical pictures and have been emphasized in the medical literature for the past four or more decades; yet it is surprising how frequently delay in diagnosis does occur.

Essentially, intracranial lesions produce two categories of signs and symptoms: (1) those of increased intracranial pressure as manifested by headache, vomiting, eye ground changes, mental changes progressing to convulsive states and bradycardia; and (2) those of localization of the lesion as detected in neurological examination.

Those spinal lesions due to extramedullary compression produce pain due to nerve root involvement with increase in pain during coughing, sneezing, or other strain. Later, there is progressive paraplegia with upper motor neurone signs, sensory loss, and sphincter paralysis.

The intramedullary tumors tend to imitate benign lesions such as syringomyelia and give initially rather bizarre symptoms and neurological findings.

Tumors affecting the cauda equina produce saddle anaesthesia with sphincter dysfunction early, later there may be complete motor loss of muscle groups in the lower limbs.

Head and Neck

Because the tissues and organs of the head and neck areas lend themselves to easy examination due to the many official approaches, diagnosis of cancer here offers little difficulty in the majority of cases. Paradoxically, it is in this same area we see some of the most extreme examples of delay in diagnosis and treatment. A large part of this is due to the increasing incidence of tobacco-smoking and the patient's complacency to feel that some cough or an

occasional episode of hoarseness is somewhat expected of him; but probably a larger part is due to the physician's apparent unwillingness to learn the simple technique of mirror laryngoscopy. Experience in this field has shown that accurate diagnosis of laryngeal cancer (both intrinsic and extrinsic) can be made in 90 per cent to 100 per cent of cases; it is likewise extremely valuable in examining the nasopharynx when a nasopharyngoscope is not available.

Nose bleeds are common; they should never be considered "idiopathic," and all too often are ascribed to hypertension. In truth any patient, particularly an adult, experiencing epistaxis without blood loss to a shock level, will have hypertension as a corporal reaction, and unless an obvious bleeding site is actually visualized by the physician, should be considered a candidate for nasopharyngeal cancer. Certainly if a bloody nasal discharge persists for a week or more, the basic disease is cancer. Given a patient with a bloody post-nasal discharge, tinnitus, and nasal obstruction, the burden of proof is to show that it is not cancer of the nasopharynx. As in the past, a high percentage of cancers of the nasopharynx will remain completely silent for a period of time and present themselves first as a metastatic node in the neck. Many of these tumors have defied detection of their primary sites for as long as a year after the metastatic node was diagnosed and treated, even by the most experienced men in the field.

Like cancer of the larynx, cancer of the antrum and other paranasal sinuses is not very common in occurrence. Bony erosion giving rise to pain and headache lead the patient to an internist, obstructive phenomena and sinusitis take him to the otorhinolaryngologist, or the malfitting dentures may make him go back to his dentist. The dentist also sees this patient first because he has pain in teeth which show no evidence of infection. X-ray examination is an excellent diagnostic means.

Pain, often referred to peculiar sites of the head and face, is often the earliest symptom of cancer of the tongue even before ulceration has taken place. Extremely useful in this site is another diagnostic tool at every physician's hand—the palpating digit, most often the index finger. Its value cannot be over-emphasized in cancer of the tongue, buccal and gingival mucosa and extrinsic laryngeal areas.

Persistent difficult or painful swallowing is due to cancer of the extrinsic larynx or anywhere in the esophagus. Hoarseness and cough (later) are early symptoms of laryngeal lesions of the supraglottic and glottic areas while dyspnea is more characteristic of infraglottic tumors. Either of these sites may be thoroughly examined with a mirror after a little practice.

Unilateral enlargement of the tonsil is highly indicative of malignant neoplasm whether it be carcinoma or lymphoma. Biopsy is immediately indicated.

It should not be necessary to iterate that any lesion of the lip or visible mucous membranes, be it nodular or ulcerated, which persists for longer than three weeks, should be biopsied.

The problem of thyroid cancer remains a great one, but as of today the safest course for the patient is to undergo hemithyroidectomy for any nodule in the gland.

Thorax

Diagnosis of tumors of these organs depends so extensively on Roentgenography, we have here only to point out the things which should lead us to investigate by this means. As before, persistent dysphagia is the earliest symptom of esophageal cancer, and in adults (the only patients who have cancer of this organ), cancer is by far the most common cause of dysphagia.

The symptoms and signs of pulmonary cancer are well-known to everyone, but these are the late signs, and unfortunately there usually are no early signs. Thus as of today, with our lack of any practical diagnostic test, we must continue to rely for early diagnosis of lung cancer on survey Roentgenograms of asymptomatic persons. On the other hand there is a decided delay in diagnosis and treatment of these lesions after symptoms have appeared. Again, because the patient smokes, he thinks nothing unusual about his occasional cough; on the contrary, the physician should never today make the diagnosis of bronchiectasis because of clubbed fingers (as in the past) before ruling out with certainty cancer of the lung.

Only for completeness' sake do I mention breast cancer; for education has been increasingly successful in breast self-examination to detect early lesions and encourage the excision and pathological examination of any suspicious mass in the breast. Delay here is almost never due to the physician, but almost 40 per cent of all breast cancer when first seen by the physician is already beyond a curable stage. This negligence is wholly the patient's unless we assume our failure in inadequate lay education.

Abdomen

Gastric cancer continues to be one of our greatest killers because of the asymptomatic course of its early, resectable, and curable state. All these patients have pain or other distress early in the disease, but these are ignored by the patient early and the physician later. The pain is rather constant and is not necessarily relieved by food, though it often is

temporarily. Anorexia is a constant complaint. Bleeding (by hematemesis or melena) is much less common than in ulcer and is a relative late symptom.

Like gastric cancer, tumors of the small and large bowel (excepting, of course, the sigmoid colon and rectum) are dependent for their diagnosis on X-ray studies. These studies show essentially patterns of obstruction of the bowel lumen. Symptoms may be those of obstruction, bleeding, alteration of bowel habits, or the presence of a mass.

It would be quite incomplete to omit emphasis on the presence of acanthosis nigrans and its association with gastro-intestinal cancer; in particular, the association of melanosis of the lips and oral membranes with colonic polyps can not be ignored. This is even more important when we realize the high percentage of infiltrating cancer arising from these benign polyps.

Diagnosis of sigmoid colonic and rectal cancer need be mentioned here only to emphasize the importance of rectal digital and sigmoidoscopic examinations in any patient with *any* anal bleeding or change in bowel habits despite the presence of obvious hemorrhoids or anal fissure.

The biliary obstructive symptoms due to cancer of the Ampulla of Vater, duodenum, common bile duct, or head of the pancreas are well-known to everyone; and there may be no early symptoms. Despite the grim prognosis for these patients, every year there are added to the medical literature a few more five-year salvages or cures by radical surgery upon the parts. Cancer of the body and tail of the pancreas remains an extremely silent tumor until secondary pressure effects cause search for medical aid. The triad of weight loss, onset of constipation, and vague but definite backache calls for X-ray examination to rule out gastric neoplasm and biliary tract disease, and if these are negative and the symptoms do not clear up on dietary and antispasmodic treatment, the patient probably should be surgically explored.

Primary hepatic cancer is rather rare in this country and almost never is diagnosed early, although at exploration, the lesion may be resectable and curable (with right or left hepatic lobectomy) even late in the disease.

Gallbladder cancer is more common than usually thought, but it is extremely insidious in its onset. Contrary to general belief this cancer is most frequently not cured (even with hepatectomy) not because of direct spread to the liver but due to lymph node metastases to the porta hepatis and aortic groups early in the disease. The association of biliary calculi and gallbladder cancer is actual, although an exact "cause and effect" relation has not been proven in human beings. Suffice it to say that many students

of this disease feel the association is so strong that all gallbladders containing calculi, even if asymptomatic, should be excised as a preventive measure.

Genito-Urinary

Signs and symptoms of these diseases are rather obvious, for the person who passes blood in his urine knows at once a serious problem is present. Later in the history of renal cancer is an abdominal or flank mass felt, but it should be remembered that one of the common causes of "fever of unknown origin" is cancer of the kidney, even in a curable stage.

Bladder cancer usually gives rise to hematuria or irritative bladder symptoms; these tumors may occur at almost any age.

Prostatic cancer causes obstructive symptoms relatively late in the disease; and here again it may be that frequent rectal digital examinations of the prostate gland in all men over 50 years of age will be the only method of finding cancer of this organ in a curable stage.

Examination of the testes for a mass is so obvious, I am reluctant to mention it; it should be noted that tumor and particularly neoplasm of this organ causes early loss of testicular sensation (deep pressure).

As any bleeding from the urinary tract is suggestive of cancer, abnormal bleeding from the female genital tract necessitates ruling out the presence of this disease. Methods of accurate cytologic diagnosis are available to every physician even in the very earliest stages.

Soft Tissue Sarcoma

The many different types and origins of these tumors makes detailed description here impractical; diagnostically, they have one thing in common—they all produce a rather localized swelling in the anatomical part. Open, incisional biopsy is probably less desirable than is aspiration needle biopsy, though the latter may not be so precise in determining the cell-origin.

Summary

1. More than 50 per cent of cancers are curable with present-day methods of treatment.

2. A plea is made, the symptoms and signs outlined, and diagnostic measures noted for the early detection of cancer and decrease in the delay before definitive treatment is afforded the patient.

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A Consideration of Fever of Undetermined Origin

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FEVER OF UNDETERMINED or unknown origin is a convenient term for the physician. Under this designation he is able to classify, in a loose fashion, those cases of undiagnosed febrile disease that come under his care.

Fever, of course, is not a *disease*. It is merely a *manifestation* of disease, albeit an important one. The disorders that can be accompanied by elevation of body temperature are legion; they include nearly every type of pathologic process¹. In view of this, it is obvious that the physician, in speaking of "F.U.O.", must avoid the error of attaching more specific diagnostic significance to fever than he would be willing to admit for other abnormal physical findings such as rales, splenomegaly, or tachycardia. It is not meant to imply that a fever curve of the relapsing type, for example, cannot give an important lead in deciding upon possible etiologies of disease. The pattern, height, periodicity, and duration of fever are all important^{2,3}. Nevertheless, the main values of fever to the clinician are the ease with which it can be detected and recorded, its objectivity as a sign of disease (there are a few important exceptions), and its convenience in communicating with his professional colleagues.

The "problem" of F.U.O. can be made considerably less diffuse if one sets up arbitrary criteria and a strict definition of the term. In the few published reports of long-term follow-up studies of patients with fevers for which no cause was discovered after careful clinical study⁴, this type of limitation has been used with justification. On the other hand, to restrict discussion to cases in which diagnosis is *never* established or to patients in whom fever is the *only* abnormal finding seems unprofitable. Similarly, without denying that the *duration* of fever is important, it can be said that there is much to be learned from cases in which a specific cause for fever has been discovered before a set period of days or weeks has elapsed. The present discussion, then, will not be limited to undiagnosed fever, to "pure" fever, uncontaminated by other abnormalities such as splenomegaly or anemia, or to fevers of any set duration.

It is appropriate also to mention the obvious fact that serious disease can exist and can progress in the absence of fever and to emphasize again that to speak of diagnostic problems in terms of body temperature is merely a convenient artefact of classification.

General Comments on the Etiology of F. U. O.

Review of published studies in which findings in groups of patients with fevers of obscure etiology have been tabulated⁵⁻⁹ makes possible certain generalizations. Variation in conditions under which such studies have been conducted, mentioned earlier, makes it impossible to state with any degree of exactness the proportion of cases that follow a given pattern.

(A) In a number of cases, etiology of fever remains undetermined. Patients may become afebrile and live for many years without disability. Fever may persist, the patient may die and, at autopsy, adequate explanation for illness may be lacking. Other than to point out that this train of events can occur and to emphasize that febrile illness of many weeks' duration can be of benign origin, as evidenced by the patient's survival, little more can be said about F.U.O. that *remains* F.U.O.

(B) The vast majority of fevers of obscure origin are caused by relatively common diseases presenting in unusual or atypical forms, rather than rare or exotic afflictions^{1, 4, 10}. Because of this, there is little to be gained by reviewing typical "textbook" descriptions of diseases producing fever. Rather, an awareness of unusual variations in the clinical manifestations of common disorders will be helpful. This truism, of course, holds for diagnostic problems of all types, with or without fever.

(C) Statistics from collected series of cases are of relatively little aid in establishing a diagnosis in the individual patient with obscure fever.

Diagnostic Procedures in F. U. O.

To date, modern medicine has devised no substitute for detailed history, thorough physical examination, and continued observation of the patient's clinical course. The search for changes in findings or the development of new signs should be unrelenting.

The importance of laboratory tests is not to be minimized. However, the variety of chemical and

Based on material presented before the Atlanta Graduate Medical Assembly, February 20, 1956.
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biological procedures now performed routinely by well-equipped clinical laboratories and the many facilities for examinations by X-ray, electrophysiological recordings, etc. that are standard equipment in modern hospitals and clinics make it imperative to utilize some selectivity in testing. Few indeed are the diagnoses established by aimless "laboratorizing." A careful consideration of possible etiologies is the only rational basis for efficient use of laboratory procedures. The responsibility for this is the physician's; he cannot delegate it to bacteriologists, biochemists, roentgenologists, or even consulting clinicians.

Often, histologic and bacteriologic examination of tissue obtained by simple biopsy is advisable and, in a few instances, it becomes necessary to subject the patient to exploratory operation. Finally, because of exhaustion of available diagnostic facilities or deterioration in a patient's condition, therapeutic trial may be justified.

Some Specific Considerations

Having belabored the points that the presence of fever is diagnostically non-specific and that virtually any type of pathologic process can, on occasion, produce the clinical picture of F.U.O., it is fitting for the writer to discuss some specific aspects of diagnosis in febrile patients. *Factitious fever*, although relatively rare, can be a source of confusion. The development in recent years of new drugs, many of which are relatively specific in their therapeutic action, including the antibiotics, has resulted in more opportunity for the occurrence of drug fever and has also lent new significance to therapeutic trial as a means of establishing the etiology of obscure febrile disease.

Factitious Fever

There is probably no other single physical finding that is as readily accepted at face value as incontrovertible evidence of the presence of organic disease as fever. It is widely recognized, of course, that malingerers sometimes manipulate thermometers in various ways so as to give the impression that fever is present¹¹. Despite knowledge of this possibility, spurious fever is rarely thought of early in a patient's course and is usually discovered by accident because of some suspicious slip on the part of the patient. The recording of body temperature of hospital patients at regular intervals is such a routine procedure, accepted without thought, that the validity of a fever curve is not usually questioned. It is so obvious that F.U.O. ceases to be a problem if the "F." component is absent, that as a routine precaution, it is worthwhile to confirm the presence of fever in any patient in whom the diagnosis is obscure. This is easily done by holding the thermometer in position each time the temperature is taken or by simply

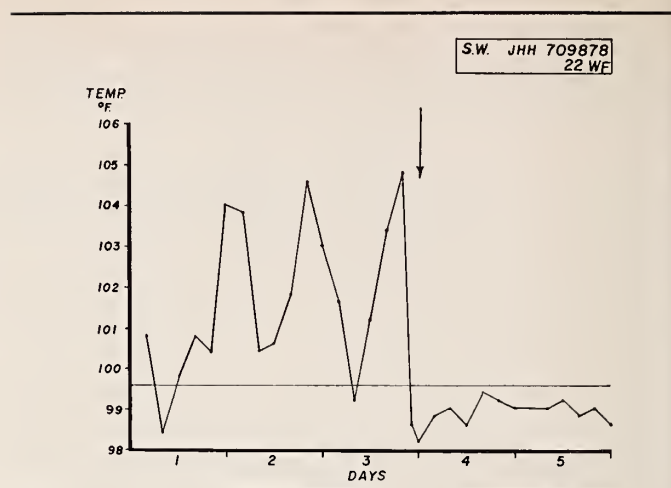


Figure 1

An example of spurious or factitious fever in a malingerer. The apparent defervescence resulted from the initiation of a regimen of holding the thermometer in place as each temperature was recorded, thus removing the opportunity for manipulation of the instrument.

making sure that an attendant remains with the patient during the process. Several points may call attention to the possibility of spurious fever. Failure of the temperature curve to follow the normal diurnal tendency to be higher in late afternoon and early evening, failure of the pulse to accelerate with sudden spikes of fever and, in particular, rapid defervescence without sweating, should all arouse suspicion³. It is worth mentioning that spurious fever is considerably more frequent in doctors, members of doctors' families, and in nurses than it is in other patients—possibly due to their being more familiar with hospital routine and to their being allowed more opportunity in the course of the recording of temperatures to manipulate the thermometer. Figure 1 illustrates the temperature curve of a young woman with a history of weight loss and intermittent bouts of fever for several months. There were no physical signs or laboratory findings to give any indication of disease other than a hectic fever. The institution of a regimen of holding the thermometer in place when rectal temperatures were recorded resulted in dramatic defervescence on the fourth hospital day. This convincing "therapeutic trial" eliminated the necessity for performing many complicated laboratory procedures, and saved the attending physician time and worry. More important, it became possible to deal with the patient's emotional problems promptly with the clear knowledge that no obscure febrile disease complicated the picture.

Drug Fever

Figure 2 illustrates the clinical course of a patient admitted to the hospital with typical pneumococcal pneumonia, bacteriologically confirmed. With the institution of treatment with penicillin, there was prompt defervescence and symptomatic improvement. At the end of the first week, although the

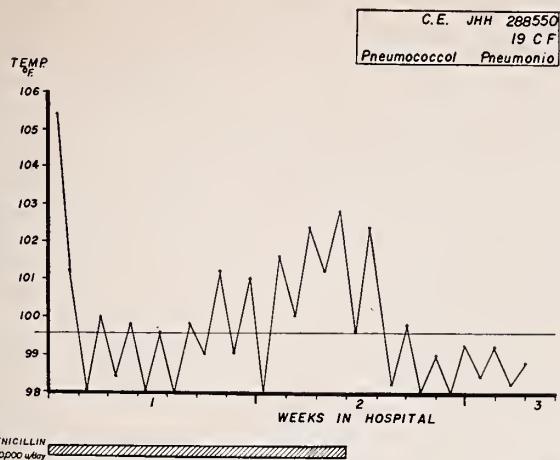


Figure 2
Drug fever produced by penicillin in a patient with subsiding pneumococcal pneumonia.

patient had no complaint, fever recurred and persisted. Physical examination showed no evidence of pleural fluid, pericarditis, meningitis or other "classic" complications of pneumonia. Blood cultures were negative and roentgenograms showed resolution of the original pneumonic process. When penicillin was discontinued, the patient's temperature returned to normal within 24 hours and she remained afebrile until discharge several days later. This is a typical example of drug fever produced by penicillin. Presumed to be a result of sensitization of some type, drug fever is often unaccompanied by skin rash or subjective complaints. Leukocytosis can occur but eosinophilia is usually absent. Of the antibiotics in common use, penicillin seems to be the commonest offender in this regard. So effective is penicillin in the eradication of pneumococcal infection in the lung, that it is fair to say that drug sensitivity is a commoner cause of recurrence of fever in patients with pneumococcal pneumonia today than are the suppurative complications we have all been taught to look for in these patients.

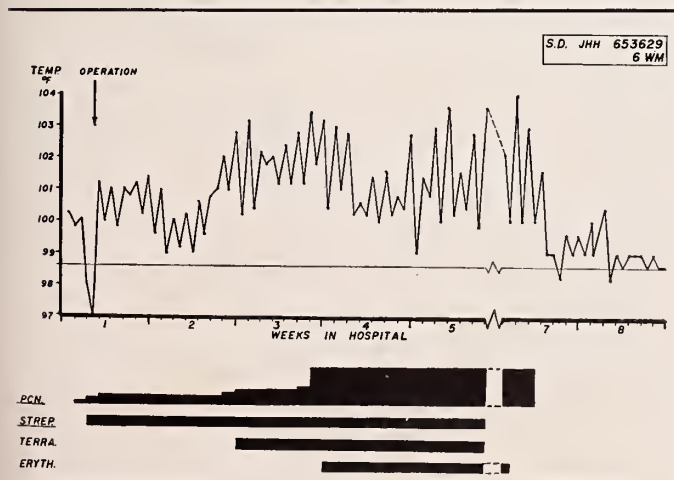


Figure 3
Prolonged drug fever produced by penicillin in a patient suspected of post-operative bacterial endocarditis.

Although the foregoing case is a relatively simple instance of F.U.O. in which discontinuing the antibiotic both established the diagnosis and cured the disease, it is easy to see how the opposite approach, i. e. increasing the dosage of penicillin, might have led to prolonged uncertainty and confusion. Figure 3 illustrates a case in which exactly this train of events took place. The patient was a boy who underwent cardiac surgery and remained febrile post-operatively despite the "routine" administration of penicillin and streptomycin. Blood cultures were negative but, because of the possibility of bacterial endocarditis, the dosage of penicillin was gradually increased and both terramycin and erythromycin were added to the regimen. The patient continued to have fever until the sixth week despite this massive antibiotic therapy. All drugs but penicillin were stopped and fever continued unabated. On the 45th day, penicillin, which he had been receiving in a dosage of 12,000,000 units daily for almost a month, was discontinued and the child promptly defervesced. He has been well since. The lesson to be learned from this case is clear. If there is failure of response to antibiotics in increasing doses (or to any other drug, for that matter) in a patient with undiagnosed febrile disease, it is wise to stop and to reassess the clinical situation at an early point before adding other agents to the regimen.

Finally, it should be pointed out that the significance of drug-induced fever is still poorly understood. The occurrence of urticaria, arthritis, or other easily recognized hypersensitivity to a drug is usually accepted as contraindicating further administration of the agent because of the danger of some more serious type of reaction such as anaphylaxis, periarthritis nodosa, etc. Whether drug fever alone carries with it a similar warning against readministration is unknown. It is a point worthy of investigation, however.

The Therapeutic Trial

Before diagnosis has been established, one may be driven to therapeutic efforts by deterioration in the condition of the patient. As Harvey and Bordley have pointed out¹ when the physician is faced with a situation in which a patient with obscure fever may have either of two diseases, one treatable, the other not amenable to other than palliative therapy, he should give the patient the benefit of the doubt. On the other hand, a trial of specific drugs may be a logical step in diagnosis in cases where extensive clinical studies have been unrevealing. In such instances, careful planning and systematic trial of various agents are possible. Several features of the use of therapeutic trials in F.U.O. are important.

Although many fevers are caused by infection and infections as a class are highly treatable diseases,

therapeutic trial is *not* synonymous with administration of antibiotics. There are other drugs with more or less specific actions including antimalarials (rarely used in this country today), antiamebic agents, salicylates, colchicine, anti-luetic drugs, and perhaps, nitrogen mustards and related compounds.

Cortisone and related steroids are so non-specific in their antipyretic and ameliorating actions as to be almost useless in therapeutic trials aimed at establishing a diagnosis.

If consideration of the diagnostic possibilities in a case leads to the conclusion that several agents might be effective, the drugs with more specific and most rapid action deserve first trial. To take a familiar example, *acute polyarthritis and fever* may be manifestations of rheumatic fever, rheumatoid disease, lupus erythematosus, gout, or gonococcal and other infections. Despite the relative ease with which the typical "textbook" example of each of these can be recognized, they are often impossible to distinguish in the individual patient, and a therapeutic trial is undertaken. Cortisone is not the first drug to be used for obvious reasons. Penicillin's action is certainly more specific than that of adrenal steroids but, in some patients with gonococcal polyarthritis, definite response to this antibiotic may be delayed for as long as two weeks. In the opinion of the writer, a trial of salicylates for rheumatic fever or colchicine for gout, where response is usually apparent within 24-48 hours should be carried out before embarking upon a course of antibiotics. Figure 4 illustrates a trial of aspirin in a patient with polyarthritis and fever. The dramatic defervescence on this drug could have been due to its non-specific antipyretic action, but the concomitant relief of joint pain and swelling indicated rheumatic fever. There was recurrence of disease when salicylates were stopped for a few days and the subsequent course bore out the diag-

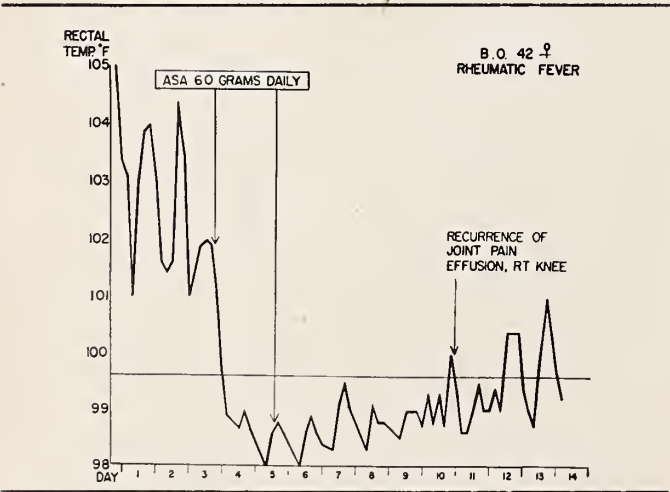


Figure 4
Dramatic result of therapeutic trial of aspirin in a patient with polyarthritis and fever. Note recurrence of joint pain and fever when salicylates were discontinued.

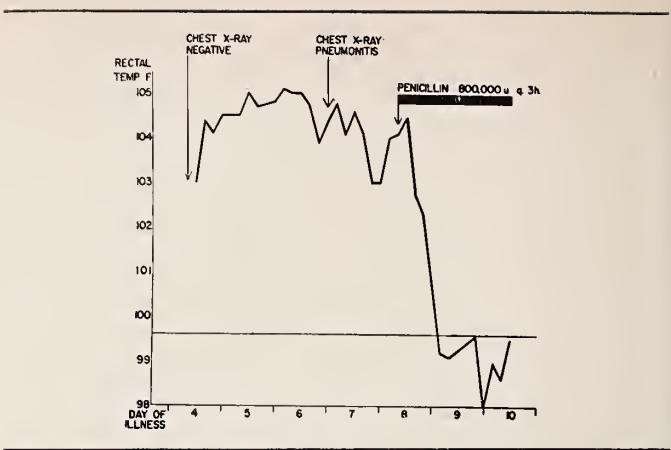


Figure 5
Therapeutic response to penicillin in a patient with psittacosis.

nosis of an initial attack of acute rheumatic fever in a 42-year-old patient.

Another example is the problem of fever and tender hepatomegaly. A response to emetine or chloroquine in such an individual would be far more meaningful than defervescence occurring after a course of penicillin and streptomycin or one of the tetracycline "broad-spectrum" antibiotics.

It is not meant to convey the impression that antibiotics are never useful in a diagnostic trial. There is enough overlapping of the antimicrobial action of these drugs to cause confusion, but in many clinical situations their use is clearly indicated and will yield highly specific information. Figure 5 illustrates an example. A 32-year-old man was hospitalized for sustained fever of about four days' duration with headache, malaise, and anorexia. Physical examination gave no clue; leukocyte count was normal and the chest was clear. However, the development of a patch of basilar pneumonitis on the third hospital day raised certain possibilities. It seemed clear that the patient did not have pneumonia caused by common pyogenic bacteria such as pneumococci, streptococci, etc. Other possibilities included, "atypical"

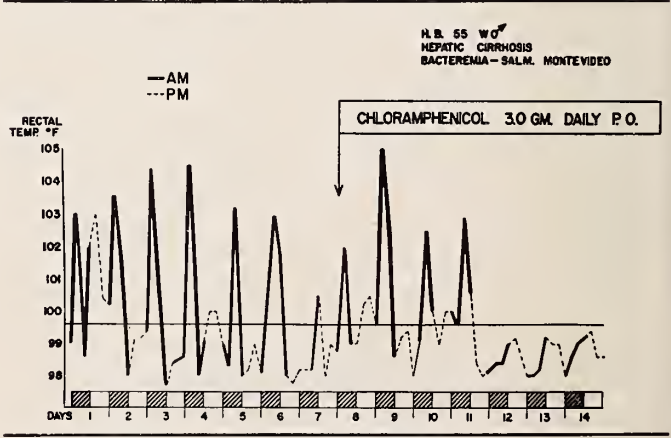


Figure 6
Result of administration of chloramphenicol to a patient with chronic bacteremia caused by Salmonella. Note the delay in defervescence. This type of response is also characteristic of typhoid treated with this antibiotic.

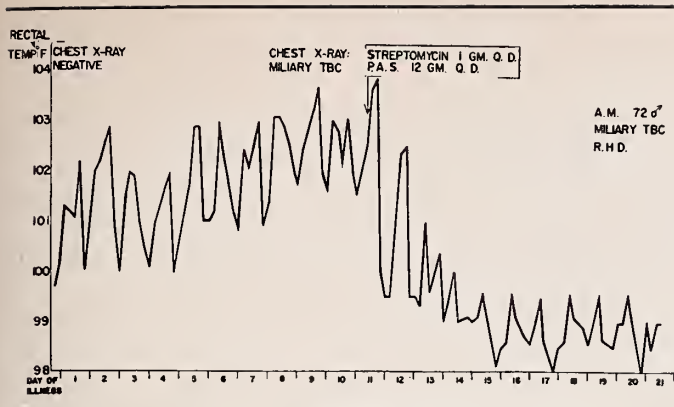


Figure 7

Prompt response of miliary tuberculosis in a 72-year-old man to administration of streptomycin and para-aminosalicylic acid.

viral pneumonia, psittacosis, tularemic pneumonia, Q-fever and, of course, tuberculosis. Of these, the only one amenable to treatment with penicillin would be psittacosis (although penicillin is not usually regarded as the drug of choice in this disease). Tetracyclines would affect atypical pneumonia (this is not fully established), psittacosis, tularemia, or Q-fever. Streptomycin would not distinguish between tularemia and tuberculosis and, furthermore, response to it in tuberculosis might take days or weeks to evaluate. The patient was therefore given penicillin with dramatic response in fever and symptoms. The diagnosis of psittacosis was confirmed some weeks later by a report of rising titer of complement-fixing antibody in the patient's serum. In this particular setting, response to penicillin was diagnostic.

The institution of a therapeutic trial carries with it the obligation to administer a drug in *adequate dosage* for an *adequate time* to establish a negative or positive outcome. This presumes some knowledge on the part of the physician of the expected range of response to a drug. The dramatic responses shown in Figures 4 and 5 are by no means typical of all such trials. For example, response to proper anti-

biotic treatment in bacterial endocarditis may require days or weeks. In typhoid or other *Salmonella* infections with bacteremia, chloramphenicol (chloromycetin) is the drug of choice. Yet it is usually several days before a response is evident. Shown in Figure 6 is the response to this drug of a patient with prolonged bacteremia due to *Salmonella montevideo*. Hectic fever continued for four days before the patient became afebrile.

Finally, a non-specific response coincident with administration of a drug can give the appearance of a misleadingly specific, even diagnostic test. In the experience of the author, this has occurred most often in dealing with the question of disseminated tuberculosis as a possible cause of obscure fever. Figure 7 illustrates a dramatic response to streptomycin and para-aminosalicylic acid in a patient who entered the hospital with fever, leukopenia and a heart murmur. Although initial roentgenogram of the chest showed the lung fields to be clear, another film taken 10 days later (as part of the program for following the development of new signs in the patient) showed typical miliary tubercles in the lung, and treatment was instituted. The prompt defervescence shown by this case is not uniform in tuberculosis and once a trial of antituberculous treatment is instituted, it should be continued for at least four weeks before a final decision is made on its effect. Streptomycin, of course, is effective in a number of non-tuberculous infections. With the availability of isoniazid and related drugs, two interesting points have been raised. First, does administration of isoniazid in tuberculosis give more rapid response than streptomycin and hence, in therapeutic trials, shorten the period needed for a decision; second, does therapeutic response to isoniazid mean more in terms of establishing a *specific* diagnosis of tuberculosis than a response to streptomycin?

On the basis of review of cases of pulmonary tuberculosis and of pelvic tuberculosis treated at the

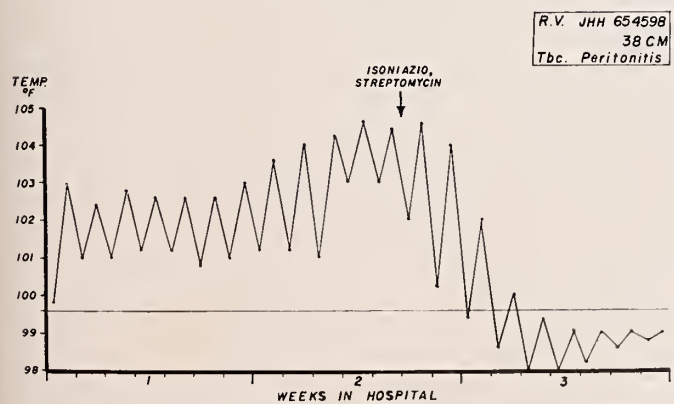


Figure 8

Defervescence after administration of anti-tuberculosis drugs to patient suspected of having tuberculous peritonitis but later shown to be suffering from lymphosarcoma.

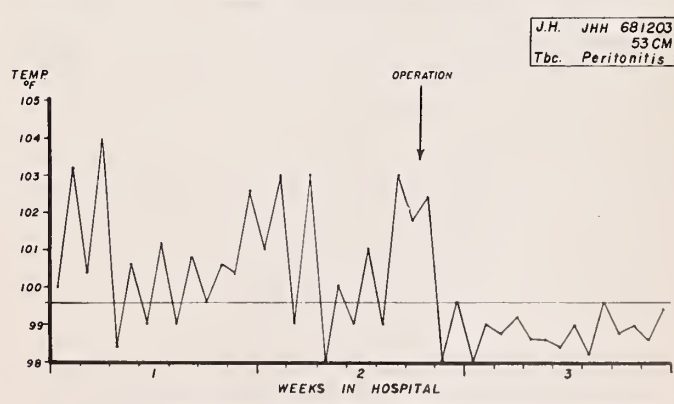


Figure 9

Defervescence in a patient believed to have tuberculous peritonitis; on operation, a carcinoma of the transverse colon with a walled-off perforation was resected.

Johns Hopkins Hospital with isoniazid or with streptomycin and para-amino-salicylic acid¹² it can be said that in these forms of the disease, therapeutic response, in the form of *lessening* of fever, is evident in 80 per cent of cases by the sixth day of treatment on either regimen and that more than 95 per cent will have responded by the end of the third week. These figures, if applicable to other forms of tuberculosis, would indicate that isoniazid had no advantage over streptomycin insofar as speed of response is concerned and that four weeks of therapy is a minimum trial period for judging results.

Figure 8 shows the clinical course of a patient admitted with fever, abdominal discomfort and swelling, and a history of exposure to tuberculosis. Tuberculin skin test was strongly positive, and abdominal fluid obtained by paracentesis was of high specific gravity. A tentative diagnosis of tuberculous peritonitis was made and treatment with isoniazid and streptomycin begun. This was followed by immediate defervescence and gradual symptomatic improvement. In view of this response, previous plans to confirm the diagnosis by exploratory laparotomy were abandoned and the patient was discharged on a home program of anti-tuberculous therapy. The improvement was short-lived; fever and abdominal swelling recurred within a few months and the patient was re-hospitalized and died soon thereafter. At autopsy, there was massive involvement of the abdomen, mediastinum, and retroperitoneal space by lymphosarcoma and no evidence of tuberculosis. Two lessons can be learned from this case: first, a "specific" therapeutic response may not be diagnostic at all and it in no way lessens the responsibility of the physician to obtain unequivocal evidence of etiology of disease; second, in this particular disease, tuberculous peritonitis, where histologic confirmation of the diagnosis is so easily obtainable, exploratory laparotomy (or some comparably effective special procedure such as peritoneoscopy in skilled hands) should precede therapy. The final chart, Figure 9, illustrates the course of another man admitted for fever, abdominal tenderness and ascites that had begun three weeks before. The patient had spent several months in a sanatorium for proven pulmonary tuberculosis a few years before, but had signed out before completion of treatment. Furthermore, roentgenogram of the lungs revealed a distinct, stringy infiltrative lesion in the left sub-apical region. The diagnosis of tuberculous peritonitis seemed clear, and the finding by paracentesis of peritoneal fluid of high specific gravity seemed to confirm this impression beyond reasonable doubt. At the insistence of a minority of the physicians in attendance (including those who had seen the patient whose course is shown in Figure 8), exploratory laparotomy was carried out be-

fore antituberculous treatment was begun. At operation, a carcinoma of the transverse colon that had perforated and produced a localized abscess was successfully resected. The patient defervesced promptly, his post-operative course was uneventful, and he is healthy and asymptomatic today, several months later. What a contrast to the situation that might have developed if isoniazid had been given on the basis of the "unequivocal" clinical evidence of tuberculous peritonitis!

Summary

The common practice among physicians of using the term "F.U.O." to designate diagnostic problems can lead to the mistaken idea that elevation of body temperature possesses some special significance as a sign of disease. The fact that most fevers of obscure origin turn out to be the result of relatively common diseases presenting in an unusual fashion and that fever can accompany almost any type of pathologic process argue effectively against such a specific interpretation. The process of establishing a diagnosis in a febrile patient differs in no essential respect from the procedure in a patient without fever. Among specific causes of puzzling febrile illness to be borne in mind are *spurious fever* in malingerers and *drug fevers*. With the advent of newer and more specific drugs, the therapeutic trial has become increasingly useful as a diagnostic test. Such trials should be carefully planned and executed and the results interpreted with caution.

The Johns Hopkins Hospital

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Why Vaginal Hysterectomy?

WILLIAM C. SHIRLEY, M.D., and JULE C. NEAL, M.D., Macon, Georgia

THE FAMILIAR QUESTION, "Why Vaginal Hysterectomy?", is often asked but is seldom answered convincingly. The physicians who ask this question usually have already made up their minds that abdominal hysterectomy is the only way to take out the uterus. In direct contrast to this point of view we first ask ourselves "can this uterus be taken out vaginally?" We feel that standard techniques in vaginal hysterectomy have now been perfected so that it is one of the safest and most satisfying of gynecological operations.

There have been many reports and discussions in the recent literature comparing abdominal versus vaginal hysterectomy. We feel these arguments are futile and unnecessary. There are certain uteri which should be taken out by the abdominal route and others in which vaginal hysterectomy is the procedure of choice. The patient's complete clinical picture and pelvic findings should dictate the procedure to be chosen. Relief of symptoms and restoration of function by the safest, speediest, and least traumatic method is the ideal searched for in all surgical procedures. We like to do vaginal hysterectomies, but we certainly are not guilty of referring patients because they have big fibroids or P. I. D. and have to be done abdominally.

The indications for vaginal hysterectomy have increased with refinements of surgical technique. The most obvious indication is the menopausal multipara with prolapse, cystocele, enterocele, rectocele, and stress incontinence. Even the "die-hards" can usually be convinced that vaginal hysterectomy and repair is the operation of choice in these cases. The less obvious cases require a little more convincing, as the increased indications are largely dependent on the operator's skill and familiarity with vaginal work.

Severe menorrhagia and metrorrhagia can be treated by vaginal hysterectomy; also fibroids which are freely movable and small enough can readily be removed vaginally. Extensive uterine bleeding in younger patients resulting in severe secondary anemia which does not respond to medical treatment or dilatation and curettement may be treated by vaginal hysterectomy; this, of course, should only

be used as a last resort. Bleeding in the menopausal patient can be readily treated by vaginal hysterectomy; besides correcting the bleeding the menopausal symptoms can then be treated with adequate hormone therapy without danger of further bleeding. We all have been faced with the perplexing problem of trying to relieve menopausal symptoms at the expense of causing undesirable and confusing bleeding from the uterus. The possibility of malignant change must always be kept in mind. We have found routine Papanicolaou smears followed by curettement at the time of surgery most useful in ruling out malignancy; this curettement also gives us a better idea as to the size of the uterus. Patients in the older age group with resistant chronic cervicitis can easily be treated by vaginal hysterectomy.

There are definite contraindications to vaginal hysterectomy, and the keynote to success in vaginal surgery is to know these contraindications and select cases accordingly. "Stunt Surgery" is to be condemned; there is no point in seeing how large a tumor can be pulled through the vagina. Patients who have extensive endometriosis, large fibromyomas, chronic pelvic inflammatory disease, ovarian tumors, and those who have undergone multiple pelvic operations should not be operated on by the vaginal route. Contrary to popular opinion, the fact that a woman is nulliparous is no contraindication to vaginal hysterectomy.

Vaginal hysterectomy is probably the oldest major surgical procedure used in gynecology. In early days, before the advent of asepsis, vaginal hysterectomy was used to rid patients of conditions which had become unbearable to them, such as procidentia or carcinomatous organs; to the amazement of the physician some of these patients lived. In the earliest days of aseptic surgery investigators were able to show that due to the increased resistance of the pelvic peritoneum and decreased soiling of the upper peritoneal cavity, the vaginal approach was safer than the abdominal. Duhrssen, in 1899, reported 500 vaginal operations and listed these reasons for his choice of his procedure.

1. Absence of abdominal scar with freedom from danger of postoperative herniation.
2. Few subjective annoyances post operatively.

Presented by Dr. Shirley before the Sixth District Medical Society, April 11, 1956, Dublin, Ga.

3. Rapid convalescence.

4. Low mortality rate.

These four reasons, along with a few more, remain as paramount advantages of vaginal hysterectomy.

Vaginal hysterectomy is preferred to abdominal hysterectomy when there is plastic work to be done on the vagina. Removal of the cervix is automatic, and plastic repair of the vagina can be accomplished safely and in much less time than having the procedure follow, or precede the abdominal operation. The fallopian tubes and ovaries should always be inspected after removal of the uterus. If there is ovarian or tubal pathology, it can usually be corrected at this time. Rarely have we had to go above to take out tubes or ovaries, but we do not hesitate to do so when the necessity is indicated. We feel that this is no more hazardous or difficult than the so called double procedure.

Safety is one of the operation's greatest assets; since it is almost entirely an extra peritoneal procedure there is little contamination of the pelvic peritoneum. This, of course, reduces the incidence of peritoneal adhesions and makes the postoperative course distinctly smoother than in abdominal hys-

terectomy. Some patients who are definitely poor surgical risks for abdominal procedure, such as obese patients and patients with various types of cardiovascular disease, can safely undergo vaginal hysterectomy. Anesthesia need not be as profound as in abdominal hysterectomy, and ambulation can be accomplished easier and more readily due to absence of the splinting which accompanies the abdominal incisions.

We feel that confidence and proficiency in vaginal hysterectomy should enable a gynecologist to relieve 70 to 80 per cent of his patients' pelvic troubles by the vaginal approach.

101 Professional Building

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The Answer to the Doctor Shortage

ALONG WITH THE pressing national shortage of scientific personnel in general there is also reported a current shortage of doctors. The situation in some quarters has been described as critical enough that some hospital authorities are searching Asian and European medical schools for interns.

Such a shortage is not exactly new. At previous times of emergency we have been made acutely aware of it. Even today, when there has been some relief, it is frequently quite a feat to obtain an appointment with a good doctor on anything like an immediate basis. There is a definite shortage in our hospitals.

The reason for this shortage is fairly obvious. The profession, admirably, has maintained high standards which insure that only the best fitted ever obtain the coveted doctor's degree. There is a shortage of training facilities. And finally, if an aspirant to medical ranks has the record, the brains and the patience to undertake the long period of apprenticeship, there is still the matter of money. A doctor's education is the longest and most expensive of any profession and it must be begun in the certain knowledge that there are no short cuts.

There have been a number of suggestions for alleviating the doctor shortage. One is the obvious one that we subsidize—through federal or state government—the training. Another is that we establish two types of medical schools. The superior of these would graduate doctors on much the same basis as they are graduated today. The other, inferior school would grant a degree which would permit of practice only in a limited field.

Frankly we like neither suggestion. We prefer our doctors to be men of proven ambition and perseverance who have received adequate training to cope with any medical situations that might arise. Our health is perhaps our most precious possession. To entrust it to the care of a man admittedly not fully trained impresses us as a rather reckless procedure.

There is little doubt, however, that the situation does call for immediate and possibly drastic remedies. Our medical profession has made too great strides for it now to be handicapped by such an elemental thing as lack of personnel. Our quotient of brains and manpower is the greatest it has ever been, and there is no basic reason that these human resources should not be fully utilized in the medical field.

Drugs in the Management of Emotional Conditions

JOSEPH S. SKOBBA, M.D., Atlanta, Georgia

EMOTIONAL PROBLEMS are manifested by a wide variety of signs and symptoms some of which are modified or eliminated by the use of drugs. The most common findings encountered are anxiety, tension, fatigue, irritability, overactivity, elation, depression, anorexia, sleep disturbance, and obsessive thinking.

Not only patients but also physicians have wished for a "pill" that would relieve the terrible suffering found in individuals suffering from emotional conditions. The physician has available a number of agents both old and new which are useful in the alleviation of the distressing symptoms. (The search is for a preparation which would relieve discomfort without interfering with alertness and which would be free of unpleasant side effects.) In the past two years there has been increasing interest in the development of new chemicals with these characteristics. These have been heralded as the "wonder drugs." of these the most widely tested have been Chlorpromazine, the Rauwolfia Alkaloids, Meprobamate, and Promazine.

The older agents, such as the bromides, barbiturates and chloral hydrate, act on the higher centers and for this reason may produce undesirable interference with alertness. In large doses and in ordinary doses in older individuals, they produce drowsiness and confusion. The newer agent, called the ataractics or tranquilizers, are considered to act on the sub-cortical centers resulting in an altered attitude towards symptoms without sedative effect. However, in some instances they have been found to produce sleep not only in the larger doses but plain ordinary doses. These agents are not without undesirable side effects. Chlorpromazine has been found to produce jaundice, hypotension, dermatitis, pseudo-parkinsonism in the high doses, and depression. Other rare complications have been reported. With the Rauwolfia Alkaloids the most common side effects have been stuffiness of the nose, hypotension, edema and depression. Some individuals using Meprobamate have reported drowsiness. With Promazine complaints of apprehension and mental dulling have been made. In a series of 20 patients no untoward effects were noted with Atarax, one of the newest

agents. Untoward emotional responses may follow the use of barbiturates, amphetamine, and cortisone. The very symptoms which one intends to combat may become aggravated. Anxiety, restlessness, irritability, nervousness and insomnia may develop as an increase of the preexisting symptoms. Bromides may be complicated by acne or where the use is self-prescribed by bromide psychosis.

As in organic conditions, the symptomatic treatment prepares the way for more definitive treatment by relieving suffering. Especially is this important in emotional difficulties where the physician-patient relationship must be established on firm ground. Only in unusual situations will the treatment of the emotionally disturbed person be successful if it consists solely of the writing of a prescription. This may suffice where the emotional reaction is temporary and of situational origin or the termination spontaneous. It is necessary that the physician explain the symptoms to the patient and describe their function to reveal the presence of an emotional difficulty. Simple examples as of blushing and perspiring under tension can be utilized to demonstrate the relation of emotions and bodily reactions to them. Most patients feel that their symptoms are considered imaginary, and the negative physical findings and laboratory examinations instead of creating the assurance only increase the fear that they will not be understood. The physician must be very positive in presenting an understandable and scientific explanation of these symptoms. This can be done very well in the instance of hyperventilation, and the ensuing symptoms of numbness and tingling of the extremities and tetany. It may even be possible to reproduce this syndrome. The patient gains confidence in the physician's recognition of the difficulty. Next the physician should explain the nature of the medication, the mode of its action and, where known, of the possible side effects. An anxious patient may be terrified by the normal delay in the action of a drug or because of the short duration of its action. Emotionally disturbed patients are very body conscious and become acutely aware of even the slightest effects of therapeutic agents.

One of the most disturbing symptoms is distur-

bance of sleep. One must keep in mind that there are different types of sleep difficulties. There is inability to fall asleep but once asleep the patient sleeps through the night. Some individuals fall asleep readily but wake up in 30 minutes unable to return to sleep. Others fall asleep easily but find that they awaken in the middle of the night with inability to return to sleep. Finally there is the early waking of the depressed patient. Each of these patterns requires a different plan of treatment. In addition, an adequate amount of sedative must be prescribed. What would suffice for an individual without an emotional disturbance will be wholly inadequate. It must be realized that by the time the patient consults the physician he has already tried all of the simple methods and used the medications recommended by his family, friends, or associates. For the patient unable to fall asleep a short acting barbiturate such as Seconal or Nembutal grains three will be necessary. Since a fear usually exists that the patient will be unable to fall asleep the prompt effect will restore his confidence in his ability to do so. Inadequate dosages used early will only make the patient more watchful and defeat the effect of later larger doses. For continuation or prolongation of sleep the use of Phenobarbital grains three may be necessary. Where this produces a hangover in the morning, Tuinal or Ethobral in the same dosages is used. Some physicians fear addiction and initially use dosages that are too small. These ineffective dosages prolong the need for medication, defeating the purpose of the small doses. Most patients reduce or eliminate their medication on their own, sometimes too soon. Those who are fearful of a return of their problem can be instructed to omit the medication on alternate nights. One of the newer agents, Doriden, has been found to be very effective in some instances where other agents have failed. In treating insomnia one must keep in mind that some patients are fearful of losing consciousness. Sedatives only increase their anxiety. They may not confess this fear but the increasing anxiety and sleeplessness should alert the physician to this complication.

Another common symptom of emotional disturbance is depression. This may be relieved by the use of the amphetamines such as Dexedrine Sulphate five to 10 milligrams at eight a.m. or upon arising. Additional medication may be required at noon. When anxiety is increased, then the addition of a sedative or the use of Dexamyl is called for. In depressions, sleep is commonly disturbed and adequate sedation as outlined above should be prescribed. In the management of the depressions, care must be taken to identify the psychotic depression. These individuals usually manifest slowing in thinking, repetitiousness of complaint, and slovenness in ap-

pearance. These should be evaluated for electroconvulsive therapy. Valuable time will be saved and the hazard of suicide minimized. More recently developed euphorants have been found to be less consistent in their action and more side effects have been noted.

There is a temptation to use stimulants in the treatment of fatigue due to anxiety and tension. These only increase the feeling of fatigue and are best avoided. Relief of tension by adequate sedation and physical exercise prove most effective measures to combat this symptom. In acute situations where the agitation and excitement are extreme and immediate control is necessary, where there is no medical contraindication, intravenous sodium amytal in the minimum dose producing narcosis may be used.

The most common emotional disturbance is anxiety. This apprehension without obvious cause results in restlessness and irritability. Masserman¹ found in his experimental neuroses in animals that sedatives retarded apperception, diminished reactivity, and partially disintegrated complex, recently acquired learned patterns of behavior. They released the animal from acquired inhibitions and aversions whether normal or neurotic. These same effects are evident in the patient treated with sedatives. The interference with cortical functions, while it may be undesirable, is necessary to relieve anxiety. In the treatment of anxiety as in the treatment of sleep disturbances, adequate dosage must be used to obtain the desired effect. The small doses will be successful principally in the older patient. While the slower acting barbiturates will suffice as maintenance agents, the more rapidly acting agents will be necessary in some individuals.

It is the treatment of this symptom of anxiety which has attracted the interest of research departments of pharmaceutical manufacturers. The increasing number of agents developed and introduced attests to the prevalence of this symptom and the need for a more satisfactory therapeutic agent. These agents have been used principally in the treatment of psychoses in state hospitals. Reports indicate that the effects there are very promising. While the early reports from the state hospital studies indicated most encouraging effects, experience in private practice has not measured up to these findings, especially in the treatment of depressions. The impression gained is that the chief result is the reduction in need for restraint, nursing care, and destructiveness. The more recent reports are more modest. Personal experience parallels that of Bennet² who found that initial improvement is followed by a recurrence of symptoms almost to their former intensity. The effects are

New Books and Exhibits for Physicians

ANOTHER PROJECT of the Georgia Heart Association is the two-volume "Electrocardiograph Test Book." The ECG volumes are designed for teaching electrocardiography in the medical schools and for postgraduate study by physicians. The work is edited by Travis Winsor, M.D., Los Angeles, Calif.

Included in the first volume of the test book are 119 electrocardiograms, each of which is accompanied by several pertinent questions. There is also a section containing 230 general questions on electrocardiography and an appendix which includes a table of normal values. The second volume contains interpretations and discussions of the electrocardiograms and answers to the questions.

The "ECG Test Book" is the result of a two-year project commissioned by the Heart Association's Committee on Professional Education. Dr. Winsor was assisted in the preparation of the volumes by 34 leading authorities in the field of electrocardiography. These physicians reviewed the work and many of their suggestions were incorporated into the final text.

Copies of the "ECG Test Book" are available from the Georgia Heart Association, 4 Twelfth Street, N. E., Atlanta. Cost is \$5.00 per set.

Health fairs sponsored by local medical societies have proven their worth as a primary means of spreading authentic health information as well as good public relations for the medical profession. At these health fairs, many American Medical Association exhibits are displayed.

One of the most popular of the Bureau of Exhibits newer displays depicts the story of human development from conception through delivery. Entitled "Life Begins," this exhibit has been duplicated so that more bookings can be arranged in the busy summer and fall months of health fairs, home shows, and state and county fairs. This exhibit is unique in that a series of 12 human fetuses are embedded in solid clear plastic for purposes of preservation and to make shipping easier. Further details on this exhibit or others suitable for the general public may be secured from the Bureau of Exhibits.

Drugs in . . . Emotional Conditions (continued)

unpredictable and sporadic and while in specific instances startling results are obtained, they are not reproducible with sufficient constancy. The main value of these agents has been as adjuvants to standard therapies.

In the treatment of hypomanic states manifested by elation, hyperactivity, and flight of ideas, Chlorpromazine has been found most effective. Twenty-five to 50 milligrams four times daily has aborted attacks in a series of six patients who on previous occasions required hospitalization and electroconvulsive therapy. All were treated on an outpatient basis and several continued their usual occupations. A trend noted recently in combining the tranquilizing agents with older sedatives or stimulants may be an indication that the search for the ideal preparation must continue.

In a discussion of the use of drugs the matter of placebos must be included. The patient who awaits the action of a drug and fails to receive it becomes more anxious, increasing the problem. In addition the discovery of this practice destroys the physician-patient relationship.

Summary

To employ drugs in the management of emotional conditions in the most effective manner the physician must be:

1. Acquainted with the action of the drug and the method of operation in the particular patient.
2. Aware that older individuals are sensitive to drugs and smaller doses will be required.
3. Consider that patients are extremely curious about changes in dosage and instructions.
4. Know the undesirable side effects of the specific drug and drugs in general and be on the look out for them.
5. In complete control of the use of the drug.
6. Alerted to the use of narcotics by any name. They are rarely if ever indicated in the treatment of emotional conditions. This includes alcohol.
7. Continuously informed of the mental processes taking place in the patient.
8. Cognizant that the relief of symptoms may not be enough.
9. Keep in mind that other forms of therapy may be more effective and their use not delayed unduly.
10. Finally it must not be forgotten that the use of drugs may have a psychotherapeutic effect apart from the pharmacological one.

490 Peachtree Street, N.E.

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¹January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.



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AMERICAN CYANAMID COMPANY
PEARL RIVER, NEW YORK

*REG. U. S. PAT. OFF.

PHOTO DATA: 8 X 10 VIEW CAMERA—WIDE ANGLE LENS,
F.32, 1/10 SEC., FLOODS AND SPOTS, ROYAL PAN FILM.

Hyperparathyroidism— Discussion and Case Report

DONALD W. SINGLETON, M.D., Atlanta, Georgia

THE LOCAL MANIFESTATIONS of hyperparathyroidism sometimes fail to suggest the presence of the disease until many blind alleys have been explored. The present case exhibited at first purely local findings and was so treated for some time before the actual diagnosis was even suspected. Giant cell tumor of the jaw may have to be differentiated from cystic demineralization. The urologist is likely to think of hyperparathyroidism when renal calculi are found, or the orthopedic surgeon when many cystic bony lesions are noted. However, the general practitioner or general surgeon needs repeated stimulation of his memory to keep this condition in mind.

The history of the parathyroid gland and its association with disease is relatively short. Courtial¹, in 1709, and Stanski², in 1839, described the bone changes which are typical of those found in hyperparathyroidism. It was not, however, until 1855 that Remak³ demonstrated the parathyroid gland. Gley⁴, in 1891, was the first to demonstrate that this gland was anatomically and physiologically distinct from the thyroid gland. Mandl⁵, a Viennese surgeon, in 1925, was possibly the first to remove a parathyroid adenoma. Alexander, Pemberton, Kepler and Broder⁶ found only 14 cases of hyperparathyroidism at Mayo Clinic from 1929 to September 1942. Keating and Cook⁷ state that in 1943 a deliberate attempt was made at Mayo Clinic to demonstrate this disease and that in two and a half years (September 30, 1942 to January 10, 1945) 24 additional cases were proved at operation. These findings have been duplicated at other clinics so that the conclusion must be that the condition is prevalent but often overlooked unless we are routinely considering it in our differential diagnosis. The symptomatic characteristics of hyperparathyroidism are often lightly mentioned but are very important if an early diagnosis is to be made. Usually the symptoms of hyperparathyroidism are anorexia, weakness, fatigue, nausea, vomiting, constipation, and generalized muscular aches and pains.

There are also skeletal symptoms such as painful bones, particularly the mandibular bone, or urinary symptoms such as polyuria and polydipsia. In the present case, however, the mandibular signs so outweighed the other manifestations that at first the true disease was overlooked.

Case Report

Mrs. J.A.P.—Age 54

The patient was first seen in the Sheffield Clinic of the Georgia Baptist Hospital on February 12, 1954, with the chief complaint of "tumors of the jaw bone." A letter from her local doctor stated that she had first been seen on December 21, 1952, with a swollen and bleeding area of the left lower gum. History revealed that the patient had worn upper false plates for 12 years and lower false plates for three years, but the onset of the present trouble had been several months prior to her first examination. At this examination by her physician, displacement of the upper plate and marked elevation of the left upper gum was noted. The patient was admitted by her physician to the hospital on March 30, 1952, and a curettement of the cystic lesions of the left maxilla and left mandible was done. Histologic report on this curettement was giant cell tumor of maxilla and mandible, possibly of low grade malignancy. The patient was next referred to a nearby cancer clinic in January 1954. At this time there was a recurrence of the gum lesions at the site of the curettement. There was an additional similar area noted by palpation in the right maxilla. X-rays of the maxilla and mandible showed extensive cystic areas, thought to be benign and of the epulis type. A repeated curettage of the left mandibular area was done on January 11, 1954, and histologic diagnosis of giant cell tumor of the lower jaw was made. Low grade malignancy was suspected. This patient was then referred to the Sheffield Cancer Clinic in Atlanta, Georgia, for consultation regarding the advisability of partial mandibulectomy.

On the patient's first visit to Sheffield Cancer Clinic a fusiform enlargement, one by three cm., was noted along the left maxillary and mandibular gingival buccal margin. The entire mandible was nodular to palpation. A two by two by one cm. nodule was noted to overlie or to be incorporated in the right lobe of the thyroid. Roentgenograms of chest, spine, skull, and long bones were normal, while those of the mandible showed multilobulated, destructive, cystic lesions consistent with giant cell tumor. The patient was admitted to the Georgia Baptist Hospital on March 14, 1954, for curettement of the lesions of the left mandible, and the pathologic

From the Department of Surgery, Georgia Baptist Hospital, Atlanta.

diagnosis was benign giant cell tumor of mandible. The patient was discharged from the hospital on March 19, 1954, and was seen in the Sheffield Clinic on March 27, 1954. It was on this visit to the Sheffield Cancer Clinic that a diagnosis of parathyroid tumor was discussed for the first time. On this visit the findings were as follows: Serum calcium 12.4 mg. per hundred cc. (normal 8.5 to 1.2); total serum protein 7.0 gm. per hundred cc. (normal 6 to 8); alkaline phosphatase 4.9 K&A units per hundred cc. (normal 2.0 to 13.0); acid phosphatase 11.2 K&A units per hundred cc. (normal 0 to 5.0); serum inorganic phosphorus 2.16 mg. per hundred cc. (normal 3 to 4); and non-protein nitrogen 30 mg. per hundred cc. (normal 25 to 35). Sulkowitch test, which is a quantitative calcium urinary excretion test, after having patient on a low calcium intake for three days, was strongly positive. Intravenous pyelogram showed no renal calculi. Because of symptoms, palpable mass in the neck, histologic diagnosis from mandibular curettement, roentgenogram of mandible, and laboratory findings, this patient was admitted for exploration of the parathyroid glands on June 29, 1954. At operation a two by two by five cm., grayish pink, soft tumor was easily identified encircling the right lobe of the thyroid. Frozen and permanent tissue sections revealed this to be an adenoma of the parathyroid. Careful examination of the other parathyroid glands revealed them to be normal. The first post-operative day the serum calcium was 7.2 per hundred cc. or low, and the serum inorganic phosphorus was 2.0 mg. per hundred cc. On the second post-operative day the serum calcium was 9.3 (within normal limits) and the serum inorganic phosphorus was 3.2 mg. per hundred cc. (within normal limits). Her hospital course was uneventful with the exception of some mild tetany symptoms on the second post-operative day. The patient was discharged on July 3, 1954, which was her fourth post-operative day. The patient was seen in the Sheffield Cancer Clinic on November 26, 1954, and at this time the serum calcium was 1.4 mg. per hundred cc. while serum inorganic phosphorus was 4.3 mg. per hundred cc. Roentgenograms of mandible showed almost complete recalcification of the previously noted cystic lesions. On September 2, 1955, the serum calcium was 11 mg. per hundred cc., and serum inorganic phosphorus was 3.6 mg, per hundred cc. Clinically the patient was improved, for before surgery she noted marked weakness and malaise. After surgery muscular aches and pains, along with soreness of the mandible were much relieved. Appetite was improved and there was return of normal bowel movements.

Discussion

The old axiom is still true that the diagnosis can not be made unless the disease is first considered in the differential diagnosis. The fatigue and malaise were obscure in this case, but if seriously considered, these might have suggested the diagnosis earlier. The physical findings of a mass in the neck and the nodular, tender mandible were of significance in this case. Histologic report of giant cell tumor and roentgenogram findings of cystic changes should have brought this disease to mind. However, the laboratory findings were much more conclusive. The elevated serum calcium with a normal total serum pro-

tein and depressed serum inorganic phosphorus with a normal non-protein nitrogen were extremely important. The elevated acid phosphatase and positive Sulkowitch, while not specific for hyperparathyroidism, were of some value in this case.

In general, the following things are important in making an accurate diagnosis of hyperparathyroidism. 1) History of anorexia, weakness, fatigue, nausea, vomiting, constipation, muscular aches or urinary symptoms. 2) Physical findings of sore or nodular mandible or of other bones. Occasionally a mass in the neck will be found. 3) Roentgenograms of bones demonstrate cystic areas. 4) Laboratory findings of elevated serum calcium and depressed serum inorganic phosphorus when total serum protein and renal function are within normal limits. 5) Histologic study of bone lesions is indicated in certain instances, and benign giant cell tumor is a common finding.

Test	Patients	Normal	Units
Serum Calcium	12.4	8.5 to 10.2	mg. per hundred cc.
Total Serum protein	7.0	6.0 to 8.0	gm. per hundred cc
Alkaline phosphatase	4.9	2.0 to 13.0	K&A units per
Acid phosphatase	11.2	0 to 5.0	hundred cc.
Serum Inorganic Phosphorus	2.16	3.0 to 4.0	mg. per hundred cc.
Non-protein nitrogen	30.0	25 to 35	mg. per hundred cc.

Table I
Initial Blood Studies done March 27, 1954 with
Normal Components

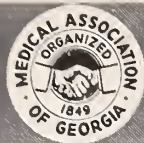
Summary

A case of hyperparathyroidism is presented. The history, signs, symptoms, histologic study, X-ray and laboratory findings were all suggestive in this case but were obscured by the local mandibular manifestation. Excision of a parathyroid adenoma gave relief of symptoms and recalcification of cystic areas of the bone. Exploration of parathyroid gland with excision of adenoma is the only treatment for this disease, and the results are often dramatic.

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Public Law 569

DURING THE LAST SESSION of Congress, Public Law 569 was passed and signed by President Eisenhower. This law is entitled "Medical Care for Dependents of Uniformed Services." Representatives of the Medical Association of Georgia had two meetings recently with a "Task Team" sent from Washington to explain this law to the doctors of Georgia, and to implement the program which this law brings into action. Under the terms of Public Law 569, spouses and children of military personnel on active duty will be entitled to private medical care. The cost of this care will be paid by the government. Both the medical fee and hospitalization are covered. Under the terms of the law no out-patient care will be rendered except for certain emergency procedures. The law covers qualified persons who require hospitalization for medical, surgical, or obstetrical care. The patient will have free choice of a doctor.

Not all dependents are qualified to receive this care. Dependents of uniformed personnel who are overseas are all qualified for this care. In addition, dependents who do not live in the vicinity of a military base are qualified. Further, those dependents living in the vicinity of a military base may get this care provided proper medical facilities are not available on the base. This situation would arise if such medical facilities were not available, or if those facilities that are available are overcrowded. As stated by the "Task Team," there exist in America some 800,000 dependents who will receive medical care under this program. The State of Georgia has more dependents than many states because of the number of military installations in the state. It has been estimated that in Georgia some 30,000 dependents will qualify for dependent medical care by private physicians. It has been predicted that approximately one out of three of these patients will require hospitalization yearly. Or, approximately 10,000 people will be treated under this program each year in Georgia.

The present plan is for the law to go into effect by December of 1956. Before that time it will be necessary for the doctors of Georgia to formulate and agree upon an adequate fee schedule, which will be the accepted standard for this program. From considerable discussion with members of the "Task Team," it has been learned that the Government does not anticipate sub-standard fees under this law, but rather that the doctors will be entitled to expect

normal fees for their services. A fee schedule will be designed by duly appointed representatives of the Medical Association and then submitted to the Government for approval.

The Government is also desirous of having the Medical Association of Georgia designate the agency through which this program will be carried out. All hospital bills will be handled by either Blue Cross or the private insurance industry. In each state the hospital bills will be handled by one agency only. But over the country it is anticipated that approximately half of the hospital bills will be handled by Blue Cross and half by private insurance agencies. The method of handling doctors' fees will be determined by each state. Under this program, the agency designated will receive, and pay, doctors bills. Each month the Government will repay to the agency the amount of money disbursed, plus administration costs of handling the program. There would be no risk involved as the Government will pay the entire expense of the program.

This law may be considered another step down the road of socialized medicine. However, further consideration reveals that it is actually an effort on the part of the Government to permit private doctors to render prepaid medical care to a segment of the population which has received this care from military medical personnel. Although it does represent medical care rendered at the Government's expense, it gives private physicians an opportunity to render this service, in addition to the military medical program. To this extent it is an improvement on the existing situation. Because of the large potential of such a program, serious thought must be given to the type of agency which will handle the medical fee program. At present there seem to be three possibilities: (1) the Blue Shield, (2) the private insurance industry, or (3) the Medical Association itself. Actually this is not an insurance program. The agency handling the medical fee payments would simply be a fiscal agent acting as a go-between for the Government and the medical profession. No risk would be involved because the Government intends to pay all costs. It is quite possible that over the next few years this type of medical coverage will be extended to a large segment of the population. In a few years it is conceivable that a significant part of each doctor's practice will involve prepaid medical programs financed by the Federal Government. For this reason, it seems important to the writer that the Medical



EDITORIALS

Association of Georgia act as its own fiscal agent in administering this program. It would seem far safer to have such a potentially large program administered by our own Association, rather than to turn it over to a commercial agency. We would act as our own "policing" agency and our own administrator. In this way we would have our best guarantee against non-professional domination, and non-medical control of professional activities.

It will be the prerogative of the Council of the Medical Association of Georgia representing the doctors of Georgia to determine who should act as our fiscal agent. This editorial has been written simply to give a brief outline of the program to be carried out and to give one opinion as to how this program might best be administered in the interest of the doctors of Georgia. It is urgently recommended that all doctors in Georgia give this matter serious thought. Any questions concerning this program can be directed to the Headquarters Office of the Medical Association of Georgia.

If broad prepaid medical programs are inevitable, then our best safeguard will be sound administration of these programs by our own medical organization on a state level. You are urged to give this matter the most careful consideration.

Bronchoscopy: A Reevaluation of an Old Procedure

THE CARDINAL INDICATIONS for bronchoscopy are familiar to all—hemoptysis, a known aspirated foreign body, obstructive collapse following a surgical procedure, an evidence of a definite hilar lesion in one of the lung fields. It is almost reflex to think immediately of bronchoscopy, when one is confronted with one of the above situations. However, those occasional patients with a persistent cough of three or more weeks, those who are having recurrent episodes of pneumonitis, those patients with a persistent wheeze, and particularly youngsters and even infants who suddenly develop a chronic cough, with associated flare-ups of pneumonitis and "asthma" are often neglected until irreversible lung damage has

been done or a possible carcinoma has already metastasized beyond the limits of resection.

Certainly the person in his late forties who has noted a change in the character of his usual cigarette cough, which has lasted for several weeks, despite the fact that he has a negative chest film, should be considered for bronchoscopic examination. With the careful use of the right angle telescopic lens together with the bronchoscope, a thorough evaluation will often reveal a small carcinoma in one of the segmental bronchi. The latter may not have caused complete bronchial occlusion of the distal broncho-pulmonary segment with the classical train of events which follow. Too often, the patient with a chronic cough which is productive of a moderate amount of purulent sputum is often referred directly for bronchograms, without considering the possibility of a prior bronchoscopy. I am sure that a bronchoscopy preceding a bronchogram is just as important as a sigmoidoscopy preceding a barium enema. A small adenoma and/or carcinoma is just as easily seen as a sigmoid adenomatous polyp and/or a rectal carcinoma. Also, it is frequently possible to thoroughly aspirate the purulent secretions which are present in cases of bronchiectasis and obtain a more satisfactory bronchogram as a result of the antecedent bronchoscopy. The story of an unsuspected foreign body in an infant or child with its sequelae of bronchiectasis and eventual irreversible lung damage is an all too familiar one. If there has been the most remote suggestion of the possibility of an aspirated foreign body, it is a relatively simple matter under a carefully given open drop ether anesthetic to examine clearly and precisely the entire endobronchial tree with its lobar orifices. The foreign body, if present, can then frequently be removed before definite lung damage has been obtained. If this is not carried out relatively early or if there is a delay of several months some type of pulmonary resection may well be necessary.

Finally, in those cases of "virus pneumonia" in which there is a persistence of the area of pneumonitis several weeks after discharge from the hospital, immediate evaluation with the strong consideration of cancer is an urgent one. Here again, bronchoscopy with biopsy and/or Papanicolaou cell smear studies will often determine an unsuspected lung carcinoma.

NEW MEMBERS

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County</i>
James Chapman Coberly	5998 Peachtree Rd., NE, Atlanta	Associate	Fulton
Aloysius Ignatius Miller	Dept. of Anatomy, Emory Univ.	Associate	Fulton
Trajan Eugene Shipley	384 Peachtree St., NE, Atlanta 8	Active	Fulton
John Thomas Yauger	340 Blvd., NE, Atlanta 12	Active	Fulton
Henry Wright Bailey	University Hospital, Augusta	Associate	Richmond
James Randall Bryan	University Hospital, Augusta	Associate	Richmond
Bowdre Lucian Carswell	Gracewood, Georgia	Associate	Richmond

The Management of Acute Pulmonary Edema

D. JAMES HUGHES, M.D., Atlanta, Georgia

ACUTE PULMONARY EDEMA represents a medical emergency. A thorough understanding of the pathological physiology of the mechanisms is essential to proper management of this dramatic and striking syndrome.

Acute pulmonary edema is a syndrome characterized by rapid flooding of the pulmonary alveoli with a serous or serosanguinous fluid. It occurs in a great variety of conditions and is not limited to individuals with cardiovascular disease. It may rapidly jeopardize the life of the patient.

Its non-specific name has led to confusion with cardiac asthma, paroxysmal nocturnal dyspnea, and chronic pulmonary edema. Chronic pulmonary edema is found in congestive heart failure. It is rarely characterized by the explosive onset seen in acute pulmonary edema. Cardiac asthma is simply the addition of asthmatic wheezes to the pulmonary edema. Paroxysmal nocturnal dyspnea occurs at night and represents a redistribution of fluid to the lungs in an individual with chronic congestive failure.

It is not the scope of this paper to enter into the lively discussion of the neurogenic versus the cardiac origin of acute pulmonary edema. There is strong evidence in favor of a pure neurogenic basis, however, since the syndrome occurs in a variety of conditions involving intense sympathetic nervous system stimuli, such as cerebral hemorrhage, fractured skull, insulin hypoglycemic coma, lumbar puncture, etc. Nonetheless, it is just as likely that these stimuli go to the heart and cause ventricular incoordination with subsequent pulmonary edema.

Treatment

Mechanical: 1. Position. First, the patient should be either propped up in bed or, better still, placed in a straight-back chair with the legs down. The latter, of course, will be impossible in a great many patients due to their clinical state. However, the cardiac output requirement is 23 per cent less in this

position than in the lying position. Secondly, breathing and aeration are much better in the sitting position. Thirdly, extra-cellular fluid volume can be pooled in the lower extremities in this position. The patient with acute pulmonary edema will almost demand to sit up, if he is conscious.

2. Use of oxygen. Since it is well proven that edema begets anoxia and anoxia begets edema, a vicious cycle may be set up in acute pulmonary edema. The proper use of oxygen would seem to be a necessity. Positive pressure oxygen for short periods of time is far superior to a tent or nasal oxygen. Carlisle presented a series of 316 cases of acute pulmonary edema due to noxious gas treated with positive pressure oxygen alone. The rest of his treatment consisted solely of strict bed rest. He observed no fatalities. This is indeed a remarkable record and not easily repudiated. I usually use positive pressure for 15 minutes out of the hour and simple nasal catheter oxygen at a flow of six liters/minute for the intervening time.

3. Tourniquets and phlebotomy. Rotating tourniquets should be used, especially if there is evidence of markedly increased venous pressure and increase in circulating fluid volume. Phlebotomy is occasionally necessary but, as a rule, is not necessarily indicated.

Drugs: 1. Morphine or central nervous system depressants. Morphine is the one drug that everybody is agreed is of the most valuable single modality in the treatment of acute pulmonary edema. Morphine alleviates the marked anxiety that these individuals have, thereby cutting down the cardiac output requirements. It also depresses the efferent-afferent reflex arc of the lung whereby edema begets more edema.

2. Aminophylline. The broncho-dilator effect and the increase in cardiac output resultant from amino-

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

The Month in Washington

IN TERMS OF ACTUAL HEALTH BILLS passed and sums of money appropriated, the 84th Congress which ended just a few weeks in advance of party presidential conventions undoubtedly set some records. Measures ranged from the far-reaching program of disability cash payments to a bill for the commissioning of male nurses in the armed services.

In between are a wide variety of measures which, in the opinion of Secretary Folsom, Secretary of Health, Education, and Welfare, gives "promise of immediate and substantial progress on a wide front in the improvement of the nation's health."

Both Mr. Folsom and the President deplored the fact that Congress had not acted on their plan for federal aid to medical schools, but Congress decided this was one of the subjects that needed more study before taking any further action. In addition Mr. Folsom expressed disappointment that nothing had been done on the authority for pooling arrangements among small health insurance companies and the long-dormant plan for a health reinsurance fund.

On medical research funds, the administration this session asked for the largest amount of money ever requested in one year. The appropriation finally voted was even larger, some \$170 million. On top of this, Congress in its final hours appropriated nearly \$80 million to carry out new legislation just passed.

Here are the highlights of major health bills approved by the 84th Congress:

Social Security Amendments—Changes in the 21-year-old social security law now include (1) Old Age and Survivors Insurance payments to disabled workers at age 50, paid from a "separate" fund, (2) extension of social security to some 250,000 dentists, lawyers, osteopaths and other self-employed persons, (3) lowering of retirement age for social security purposes for women from 65 to 62, (4) earmarked

payments for medical care of public assistance recipients, and (5) increase of payroll deductions by one-half of one per cent and three-eighths of one per cent for the self-employed.

Laboratory Research Facilities—The Hill-Bridges bill for \$90 million in construction grants over three years to public and non-profit institutions to erect research facilities started out in the Senate as a bill to aid research in crippling and killing diseases but wound up for research in all "sciences related to health."

Health Amendment Act—The so-called little omnibus health bill provides for federal grants for training of public health specialists, professional nurses qualified for teaching and administrative jobs and for practical nurses—plus a two-year extension beyond next July 1 of the 10-year-old Hill-Burton hospital program, and special projects grants for mental health studies and demonstrations.

Medical Care for Military Dependents—A long-sought goal of the Defense Department was enactment of a permanent program of medical care for dependents of armed services personnel either in military hospitals and clinics or through private sources. It is scheduled to begin early in December.

National Library of Medicine—Another proposal long in the making was the reestablishment of the Armed Forces Medical Library as the National Library of Medicine. For administrative purposes, Congress put it under the Department of HEW, but left up to the 17-man board of regents the selection of site—in all likelihood in the Washington area.

Sickness Survey—Special and continuing surveys on the extent of illness and disability in the U. S., along with medical care being offered, have been authorized—the first detailed study of its kind in over 20 years. The work will be done by the Public Health Service.

Heart Page (continued)

phylline administration make it a very valuable adjunct in the treatment of acute pulmonary edema. Except in cases of acute myocardial infarction, aminophylline should be routinely given intravenously in a dosage of three and three-fourths grains, taking at least 10 minutes for injection.

3. Digitalis. Full rapid digitalization should be carried out on patients other than those with acute myocardial infarction. In acute myocardial infarction, when digitalization seems necessary, slow digitaliza-

tion should be carried out. Many people feel that the danger of digitalization outweighs the advantage if a myocardial infarction is present.

Summary

There is no unanimity of opinion regarding the management of acute pulmonary edema. The author has not attempted to present the pros and cons of the various modalities used in treatment but feels that those which have been discussed tend to lower effectively the mortality rate.

physician's bookshelf



REVIEWS

Guyton, Arthur C., M.D., **TEXTBOOK OF MEDICAL PHYSIOLOGY**, W. B. Saunders Company, Philadelphia, 1956, 1030 pp., 577 figs., \$13.50.

This is a textbook written for medical students, and the author has done an admirable job. It is well organized, concise, and clear. The tremendous mass of accumulated material in this field is presented in a logical and readable way avoiding highly technical discussions of controversial points. The author frequently discusses the pathological physiology of appropriate disease states thereby maintaining the reader's interest in what is necessarily at times rather dry subject matter. At the end of each chapter is an extensive bibliography including classic and recent contributions to that particular field. Separate chapters on aviation and deep-sea diving physiology and on radiation add rightful emphasis to these phases which have become so increasingly important in the past few years.

This volume should find wide use as a textbook and also as a reference source for the practicing physician.

Oscar M. Mims, M.D.

Wolff, Louis, M.D., **ELECTROCARDIOGRAPHY, FUNDAMENTALS AND CLINICAL APPLICATION**, second edition, W. B. Saunders Company, Philadelphia, 1956, 342 pp., 199 figs., \$7.00.

This is an interesting book for the experienced electrocardiographer to keep in his library for study and reference. Many fascinating electrocardiograms are illustrated and accompanied by well-written interpretations and discussions. The book is a failure, however, in so far as its ability to bring the neophyte from the basic fundamentals into the realm of clinical interpretation in an orderly fashion, which the author apparently intends to do, and the text is not a good one from this standpoint.

Part I appropriately considers the basic principles of electrocardiography. These several chapters are well-written and informative, but difficult for the beginner or occasional student to grasp and understand unless he is well-grounded in the fundamentals of electrophysiology. Chapters 11, 12, 13, and 14 consider abnormal electrocardiograms long before the reader, studying in a chronological order, would have any concept of the normal tracing.

Part II deals with clinical electrocardiography, in general a very interesting treatise. Here, as in other portions, however, long descriptive passages of electrocardiograms are found where effectiveness would have been markedly increased by using well-placed, labeled diagrammatic sketches or blown-up tracings.

The normal and abnormal cardiac mechanism, Digitalis, and Quinidine are considered in the final 10 chapters composing Part Three. There are many excellent discussions in this portion, particularly, and the correlation between clinical and graphic findings is well-described. Here, too, however, are found many glaring faults, particularly with regard to arrangement. The chapter on flutter and fibrillation, for instance, appears with scarcely any description of what these arrhythmias are. The reader finds himself studying tracings of auri-

cular flutter with no knowledge from the text of what flutter is. The last chapter deals with the simple topic of atrioventricular block, which by all means should have been one of the first abnormalities discussed.

Simone Brocato, M.D.

Fluhmann, C. Frederic, B.A., M.D., C.M., **THE MANAGEMENT OF MENSTRUAL DISORDERS**, W. B. Saunders Company, 1956, 121 figs., 350 pp., \$8.50.

This is an excellent new book emphasizing the clinical management of the various menstrual disorders with which the medical practitioner is frequently in contact. The anatomic and physiologic changes of normal as well as abnormal menstruation are very adequately discussed. The author thoroughly covers the organic and functional menstrual disorders and treatment. There are excellent chapters on the two age epochs, adolescence and climacterium, with a complete discussion of the disorders arising at these times. The gonatropic and steroid hormones are covered in separate chapters, and an up-to-date summary of the uses, dosages and contraindications of the present day commercially available sex hormone preparations is given. Throughout the book the author gives constant consideration to the relations between aberrations of the menstrual function and non-menstrual uterine bleeding which is of great interest in a time of cancer awareness.

This book should prove to be very valuable and interesting reading to the general practitioner as well as to the specialist in gynecology.

William C. Helms, M.D.

Hinshaw, H. Corwin, M.D., Ph.D., and L. Henry Garland, M.B., B.Ch., **DISEASES OF THE CHEST**, W. B. Saunders Company, Philadelphia, 1956, 727 pp., 277 figs., \$15.00.

Diseases of the Chest is a brand new volume devoted exclusively to pulmonary disease (usually books on the chest include discussions of heart disease).

The contents are divided into 40 chapters which cover practically every conceivable chest condition.

Written in a rather brisk, close-cropped and sometime dogmatic style this volume supplies a concise reference text for student or practitioner.

A rather novel introductory begins the book with a brief discussion of thoracic complaints as to etiology, pathogenesis, and clinical significance. This section is the most readable, and in many ways, the best section of the book.

The discussion on tuberculosis is most complete and has presented clearly the problems that the changing aspects of anti-microbial treatment have brought forth. The discussions of the various regimes of treatment are outlined with the pros and cons nicely presented.

The authors have condensed the myriads of reports which have flooded the recent literature on management of tuberculosis in a very commendable fashion so that only the regimes of proven value are presented, those drugs or treatments of questionable value are dismissed as briefly as possible.

The size of this book, the format, and above all the illustrations are excellent in all details. It is a valuable addition to our library of texts.

Bernard P. Wolff, M.D.

THE ASSOCIATION

Executive Committee of Council

August 5, 1956, Lakemont, Ga.

THE REGULAR AUGUST meeting of the Executive Committee of Council was called to order by Chairman J. W. Chambers, LaGrange, at Lakemont, Georgia, 9:30 A.M., Sunday, August 5, 1956.

Present were Hal M. Davison, Atlanta, President; W. Bruce Schaefer, Toccoa, President-elect; H. Dawson Allen, Jr., Milledgeville, Immediate Past President; J. W. Chambers, LaGrange, Council Chairman; Edgar Woody, Jr., Atlanta, *JMAG* Editor; and Mr. Milton D. Krueger, Atlanta, Executive Secretary.

The minutes of the July 1 meeting were read and approved.

ASSOCIATION TAX DATA—Hal M. Davison presented a report concerning the tax status of the Association. Dr. Davison recommended that the matter be referred to the full Council at the September meeting.

LEGAL COUNSEL COMMITTEE REPORT—Dr. Davison, Chairman of the Legal Counsel Committee, reported on the activity of his committee in connection with the 1956 House of Delegates resolution that the Association seek legal counsel on the status of medicine in Georgia, particularly in regard to the "corporate practice of medicine." A communication from the firm of Alston, Sibley, Miller, Spann and Shackelford, Attorneys at Law, Atlanta, re: the possible representation of the Medical Association of Georgia in matters concerning practice of medicine, was read. It was moved that the Executive Committee of Council recommend that Council accept the recommendation of the Legal Counsel Committee in having the firm of Alston, Sibley, Miller, Spann and Shackelford represent the MAG in this area. This motion was approved, and the matter was referred to Council for decision at the September 1956 meeting.

AMA MILITARY DEPENDENTS MEDICAL CARE MEETING—David Henry Poer, Secretary, attended a meeting sponsored by the American Medical Association on the subject of military dependents' medical care, July 28, 1956, Chicago. Mr. Krueger, reporting for Dr. Poer, discussed the proposed Defense, Health, Education and Welfare directive for the implementation of the dependents section of the Dependents' Medical Care Act (Public Law 569), as presented at the AMA meeting. The proceedings of this meeting were made known to the Executive Committee. Mr. Krueger then asked the Executive Committee for authorization for a Medical Association of Georgia sponsored Regional Meeting on the problems inherent in Public Law 569. Nine other Southeastern States were to be invited. It was moved that the MAG be authorized to sponsor this Regional Southeastern State Medical Associations meeting on Public Law 569, and that a maximum of \$50.00 be appropriated to cover incidental expenses of the proposed August 19, 1956, meeting. It was further moved that certain members of the MAG Insurance and Economics Committee and the MAG Veterans' Affairs Committee be invited to attend this

meeting, along with the officers, Council and key representatives from the MAG, and that both non-profit and insurance organizations and hospital authorities be asked to attend the meeting. These motions were approved.

MEDICAL PRACTICE ACT REVISION REPORT—David Henry Poer, Secretary, serving as a member in behalf of the MAG on a Liaison Committee with the Board of Medical Examiners to consider revisions of the Georgia Medical Practice Act, submitted a report concerning proposed changes on the injunction and revocation sections of the present act. The report further stated that the problem of temporary licensing of foreign graduates and/or registration has yet to be worked out. On the basis of this information, it was moved that the proposed changes in the Medical Practice Act concerning revocation and injunction as worked out by this Liaison Committee be approved as submitted to the Executive Committee of Council. This was approved. The report further stated that the Medical Examining Board had, prior to this meeting, approved these changes.

MAG JOURNAL SOUTHEASTERN STATE MEDICAL JOURNAL CONFERENCE—Edgar Woody, Jr., Editor of the *Journal of the Medical Association of Georgia*, presented a report of progress on the November 3-4, Atlanta, Southeastern State Medical Journal Conference which is being sponsored by the Medical Association of Georgia. The report was received for information, and Dr. Woody was commended for his efforts in this area.

MAG JOURNAL TRAVEL APPROPRIATION—Edgar Woody, Jr., *JMAG* Editor, informed the Executive Committee of Council that the *Journal of the Medical Association of Georgia* had been notified that it will be awarded a plaque in recognition of its general excellence. Dr. Woody asked for an appropriation to cover the travel and hotel expense at this meeting for himself as *JMAG* Editor, and for Miss Frances Porcher, *JMAG* Managing Editor. It was moved that a maximum of \$200.00 be allocated for this purpose; the motion was approved.

REVIEW OF COMMITTEE APPOINTMENTS—Mr. Krueger asked that a review of the recent committee appointments be read into the Executive Committee of Council minutes as follows:

(1) *Lectureship Committee*—(Appointed by Council Chairman and Secretary by authority of Council, July 1, 1956)—David Henry Poer, Atlanta, chairman; H. L. Cheves, Union Point; Glenville Giddings, Atlanta; Thomas Findley, Augusta; and Eugene B. Ferris, Atlanta.

(2) *Milledgeville Study Commission*—(Appointed by Council Chairman by authority of Council, June 3 and July 1, 1956)—Rives Chalmers, Atlanta, and Richard E. Felder, Atlanta.

(3) *Medical Education Subcommittee*—(Appointed by Medical Education Committee and others).

Emory—Charles S. Stone, chairman, Atlanta (MAG Medical Education Committee); Elliott Scarborough, Atlanta (Emory School of Medicine); H. B. Cason, Warrenton (Emory Alumni Association); Dean Arthur Richardson, Atlanta, *ex-officio*; and J. W. Chambers, LaGrange, *ex-officio*.

Medical College of Georgia—R. C. McGahee, Augusta, Chairman, (MAG Medical Education Committee); A. W. Simpson, Washington (Medical College of Georgia Alumni Association); a representative to be named by the president of the Medical College of Georgia; President Edgar R. Pund, Augusta, *ex-officio*; and Thomas W. Goodwin, Augusta, *ex-officio*.

(4) *Workmen's Compensation Study Committee*—(Appointed by Council Chairman on authority of Council, June 3, 1956)—Bernard P. Wolff, Atlanta, chairman; Charles R. Andrews, Canton; and J. S. Holder, LaGrange.

(5) *History and Vital Statistics Study Committee*—(Appointed by the president on authority of Council, June 3, 1956)—C. C. Aven, Marietta, chairman; Cyrus Strickler, Jr., Atlanta; and Herbert S. Alden, Atlanta.

On notification from George H. Alexander, at his request, the Executive Committee of Council moved that he be relieved of duties on the MAG Mental Health Committee and the Maternal and Infant Welfare Committee and that the chairman of these two committees be so advised and further asked to make recommendations to the Executive Committee for appointees to fill these vacancies.

HEADQUARTERS OFFICE REPORT—Mr. Krueger discussed fully the State Medical Education Board, its present function and its progress, which was received as information. He also informed the Executive Committee of Council of the July 11, 1956, Board of Regents' action concerning the Talmadge Memorial Hospital and read a communication dated July 12, from

Mr. L. R. Seibert, Executive Secretary of the Board of Regents as follows:

"At its meeting on July 11, 1956, the Board of Regents authorized no change in the policies established for the operation of the Eugene Talmadge Memorial Hospital. It was the opinion of the Board that the request of the House of Delegates of the Medical Association of Georgia may be carried out within the framework of the plan already approved by the Board of Regents.

"The Board of Regents authorized the president of the Medical College of Georgia to carry out the request of the House of Delegates as far as practicable and the administrative matter within the framework of the present policy.

"At a later date, I shall send you an excerpt from the minutes of this meeting concerning this action of the Board.

SIGNED: L. R. Seibert,
Executive Secretary."

Information was received on the progress made by the Annual Session Committee of Council.

Mr. Krueger presented to the Executive Committee an invitation from James N. Hicks, Brunswick, Georgia, for the full Council to meet September 15 and 16 in Brunswick. This invitation was accepted with the thanks of the Council.

Chairman Chambers called for unfinished business, and there being none, he called for new business, and there being none, the meeting adjourned at 11:15 A.M.

Physicians Licensed by Reciprocity

THE FOLLOWING PHYSICIANS were licensed by reciprocity by the State Board of Medical Examiners on June 14, 1956:

John Winston Adams, Jr.
2401 Wiehl St., Chattanooga, Tenn.
William Walker Allen
1106 Westmoreland Ave.,
Norfolk 8, Va.
Frank Pearson Anderson, Jr.
1011 Oakland Ave., Durham, N. C.
Ira Lee Arnold, Jr.
3504 Dell Trail, Chattanooga, Tenn.
Benjamin Bashinski, Jr.
839 First St., Macon, Ga.
Alfred McDowell Bennett
2080 N. Decatur Rd., N.E.,
Atlanta, Ga.
Floyd Edward Bliven, Jr.
Dept. of Surgery, Medical College of
Georgia, Eugene Talmadge Memorial
Hospital, Augusta, Ga.
Kenneth Joseph Boniface
738 Medway Rd., Riverland Golfview,
Charleston 43, S. C.
Brown Hill Boswell
Box 332, Donaldsonville, Ga.
John Reuben Bottomy
962 Clifton Rd., N.E., Atlanta, Ga.
Edwin Leland Brackney
Dept. of Surgery, Medical College of
Georgia, Augusta, Ga.
Henry Aimar Brandt
Veterans Administration Hospital,
Augusta, Ga.
Warren Franklin Brown
2167 Mt. Paran Rd., N.W.,
Atlanta, Ga.

Henry Jonathan Climo
340 Boulevard, N.E., Rm. 611,
Atlanta, Ga.
Avery Lon Cotton
817 Columbia Dr., Belvedere Plaza,
Decatur, Ga.
George deMuro Dame
DuVal Medical Center, 2000 Jefferson
St., Jacksonville, Fla.
Robert George Demos
Chattanooga, Tenn.
Bert H. Ellis
3043 Sherwood Dr., Brunswick, Ga.
Richard Van Fletcher
540 McCallie Ave.,
Chattanooga, Tenn.
Park Lambuth Gerdine
616 N. Court St., Quitman, Ga.
Jennings Melvin Grisamore
4138 Caldwell Rd., Atlanta 19, Ga.
Wayne Willard Hall
515 Broadway, Paterson, N. J.
Bennett Brown Harvey
U. S. Veterans Hosp., Lake City, Fla.
Lewis Bailey Hasty
1553 Shoup Court, Apt. 4,
Decatur, Ga.
James Morris Higginbotham
253 Shallowford Rd.,
Chattanooga, Tenn.
James Rutherford Stanton Himebaugh
2620 Kessler Blvd.,
Indianapolis, Ind.

William Edward Holladay, Jr.
1017 Maxwell House Apts.,
Augusta, Ga.
Lionel Arnold Jacoby
Rt. 3, Stone Mountain, Ga.
Dorothy Steinle Jaeger-Lee
3825 Wieuca Rd., N.E.,
Atlanta 5, Ga.
George Robert Jaudon
West Point, Ga.
James Hoyt Jenkins, Jr.
Harbin Clinic, Rome, Ga.
James Edward Johnson
4547 Brainerd Rd.,
Chattanooga, Tenn.
Dan B. Kahle
3254 Peachtree Rd., N.E.,
Atlanta, Ga.
John William Kemble
Box 242, Letterman Army Hosp.,
San Francisco, Calif.
Gene Haviland Kistler
20103 Medical Arts Bldg.,
Chattanooga, Tenn.
George Ibarra Leboss
Essex County Sanatorium,
Verona, N. J.
Thomas Laidlaw Linn
c/o The City Hosp., Columbus, Ga.
Joseph Henry McCormick, Jr.
117 E. Jones St., Savannah, Ga.
George Anderson Mitchell
504 Medical Arts Bldg.,
Chattanooga, Tenn.

Thomas Francis Mogan
1464 Fairbanks, S.W., Atlanta, Ga.
William Henry Moretz
2345 McDowell St., Augusta, Ga.
William Ray Murphy
2205 Crestwood Dr., Augusta, Ga.
George Marvin Owens
552 W. Peachtree, N.W., Atlanta, Ga.
William Andrew Paris
742 Shamrock Dr., Decatur, Ga.
Prentiss Edward Parker, Jr.
Grady Memorial Hosp., Atlanta, Ga.
Woodrow Wilson Payne
764 McConnell, Memphis, Tenn.
Andro Peter Phillips
323 E. Jones St., Savannah, Ga.
DeSaussure Ford Philpot, Jr.
Neurological Institute,
710 W. 168th St., New York, N. Y.
Guillermo M. Pujadas
45 Ferry Ave.,
Fort Walton Beach, Fla.
Oscar Leo Redwine
Emory University Hosp.,
Emory University, Ga.
Walter Gowans Rice
Dept. of Pathology,
Medical College of Georgia,
Augusta, Ga.

Jacob C. Rosen
Box 476, Darien, Ga.
Mary Wheatland Schley
303 - 11th St., Columbus, Ga.
Albert John Schneider
4083 Pinehill Dr., Decatur, Ga.
Trajan Eugene Shipley
2908 Ridgemore Rd., N.W.,
Atlanta 18, Ga.
George Williams Smith
2223 Kings Way, Augusta, Ga.
Ralph Merrill Stephan
2310 Stewart Ave., S.W.,
Atlanta 15, Ga.
Alexander Szecsey
2503 Acorn Ave., N.E., Atlanta, Ga.
Henry Joseph Tanner
553 W. Peachtree, Atlanta, Ga.
Roy Frank Thagard
509 1/2 Gloucester St., Brunswick, Ga.
Paul C. Thompson
2609 Robins, Chattanooga, Tenn.
William Gentry Thurman
City Hospital, Columbus, Ga.
Alexander Vanderburgh
85 Main St., Brewster, N. Y.

Robert John Van de Wetering
954 Lindbergh Dr., N.E.,
Atlanta, Ga.
John Wade Walker, Jr.
1290 Park Ave., S.E., Apt. A.,
Atlanta, Ga.
Robert Jeffreys Walker, Jr.
779 Downing St., Macon, Ga.
William Charles Wansker
Veterans Administration Hosp.,
Atlanta 19, Ga.
Clinton Ellsworth Warner
130 Wellington St., S.W.,
Atlanta, Ga.
William Howard Waugh
Dept. of Physiology,
Medical College of Georgia,
Augusta, Ga.
Herbert Lewis Weininger
91 East 208th St.,
Bronx 67, New York, N. Y.
Charles L. Whisnant, Jr.
762 Cypress, N.E., Atlanta, Ga.
Lawson Spires Whitaker, II
518 McCallie Ave.,
Chattanooga, Tenn.
Russell Wigh
Eugene Talmadge Memorial Hosp.,
Augusta, Ga.

Physicians Licensed by Examination

THE FOLLOWING PHYSICIANS were licensed by examination by the State Board of Medical Examiners on July 26, 1956:

James L. Achord
Alamo, Ga.
John Hannay Affleck
128 Fairview Ave., Decatur, Ga.
Errett Cyril Albritton
1335 H St., N.W.,
Washington 5, D. C.
Robert Hoyt Anderson, Jr.
908 N. Patterson St., Valdosta, Ga.
John Robert Arnall
Fayetteville, Ga.
Edward Leroy Askren, III
685 Timm Valley Rd., N.E.,
Atlanta, Ga.
Royce Estes Banister
Ila, Ga.
Walter Joseph Barial
785 N. Pascagoula St.,
Pascagoula, Miss.
William Earnest Barron, Jr.
68 First Ave., Newnan, Ga.
Joseph Diehl Beasley
426 Fayetteville Rd., Decatur, Ga.
Warren Lewis Belding
136 West 20th St., Jacksonville, Fla.
Leonard Hyman Berger
141 East 56th St., Savannah, Ga.
Jack Edwin Birge
143 Willow Lane, Decatur, Ga.
John Corbett Blalock, Jr.
734 W. Wesley Rd., Atlanta, Ga.
Shatteen Taylor Blalock
734 W. Wesley Rd., N.W.,
Atlanta, Ga.
Joseph Aldean Blissit
Locust Grove, Ga.
John Alfred Bowers
42 South Bingham St.,
Memphis, Tenn.
Lawrence Tecumseh Brannon
2080 N. Decatur Rd., N.E., Apt. Q.,
Atlanta, Ga.
Samuel Alton Brewton, Jr.
404 Howell St., Thomaston, Ga.

James Frank Brooks
93 Myrtle Courts, Augusta, Ga.
Dennis William Brosnan, III
1031 Wadsworth Dr., N.W.,
Atlanta, Ga.
Cyrus Uriah Brown
2903 Roanoke Ave.,
Newport News, Ga.
Nelson Harry Brown
2710 Oakland Dr., Augusta, Ga.
Fred Jeff Burford
112 W. College Ave., Decatur, Ga.
Nathaniel Washington Burks, Jr.
1215 Tuscaloosa St.,
Montgomery, Ala.
Claude McLeod Burpee
1127 Monte Sano Ave., Augusta, Ga.
Hubert Riviere Buxton, Jr.
P.J. O. Box 134, Sardis, Ga.
Robert Cable, II
Apt. 1-A, Keystone Apts.,
Augusta, Ga.
Helen Mead Caffey
4230 Columbia Pipe, Apt. 21,
Arlington 4, Va.
William Cleveland Caldwell
Emory Univ., Emory University, Ga.
Albert Carey
2038 Bainbridge St., Philadelphia, Pa.
Andrew Jackson Carr
4436 - 45th Ave., Birmingham, Ala.
Nelson Slappey Carswell, Jr.
222 Elm St., Dublin, Ga.
William Hill Cherry, Jr.
610 Broad St., LaGrange, Ga.
David D. Chube
St. Margaret Hosp., Hammond, Ind.
Dewey Monroe Clayton, III
Rt. 1, Box 57, Timberlake, N. C.
James David Clements
Pineview, Ga.
John Walton Collette
Box 1098, Emory University, Ga.

Torrence Junius Collier, Jr.
214 Garden St., Hot Springs, Ark.
Leonard LeRoy Cotts
1260 Greene St., Augusta, Ga.
Thomas Edward Cummings
204 Piedmont Ave., Rockmart, Ga.
John Ingram Dickinson
1942 Candler Rd., N.E.,
Brookhaven, Ga.
Roy Henry Dippy
Box 1068, Emory University, Ga.
Dorothy Skene Dobbs
c/o Mrs. Alice Skene,
1248 Lucile Ave., S.W., Atlanta, Ga.
Laurie Lester Dozier, Jr.
85 Roswell Court, N.E., Atlanta, Ga.
Arthur Derby Draper, Jr.
Route No. 1, Palmetto, Ga.
Thomas Earle Dukes, Jr.
1550 Farnell Court, Apt. 8,
Decatur, Ga.
William George Dunbar
4204 Osborne Rd., Atlanta, Ga.
Joseph Albert Eaddy
Box 1006, Emory University, Ga.
Allan Greer Edwards, Jr.
404 Cherokee, Marietta, Ga.
William Roquemore Edwards, Jr.
1616 Maryland Dr., Albany, Ga.
William Raymond Faust
916 Torrey Ave., Ocala, Fla.
William Edward Finlayson
1305 Meharry Blvd., Nashville, Tenn.
Paul Edward Fitzpatrick
Yatesville, Ga.
Howard Carroll Friday
Piedmont Hosp., Capitol Ave.,
Atlanta, Ga.
Ronald Frost Galloway
291 Parkway Dr., Apt. 6,
Atlanta, Ga.
Edward William Geathers
322 Avenue O, S.W.,
Winter Haven, Fla.

- Thomas McGibony Geer
P. O. Box 102, Greensboro, Ga.
- Benjamin Robert Gendel
Vet. Admin. Hosp., Atlanta 19, Ga.
- Ridley McVeston Glover
1795 Oconee Pasc.,
North Atlanta 19, Ga.
- Egon Goldhammer
Battey State Hosp., Rome, Ga.
- Joseph Cholmondeley Greenfield, Jr.
1105 Berkshire Rd., N.E.,
Atlanta, Ga.
- Joe Leonard Griffith
R. F. D. No. 3, Jefferson, Ga.
- John Bunyan Griffin, Jr.
1074 Springdale Rd., N.E.,
Atlanta, Ga.
- Joseph Howard Griner
201 - 3rd St., S.E., Cairo, Ga.
- Chenault William Hailey
Hartwell, Ga.
- John William Haith, Jr.
515 Apple St., Burlington, N. C.
- James Alden Hall
333 West 11th St., Jacksonville, Fla.
- Jesse Denny Hall, Jr.
900 W. Wesley Rd., N.W.,
Atlanta, Ga.
- Catherine Latane Hamilton
University Hosp., Augusta, Ga.
- Edsel Lanier Harrell
5532 Keystone Dr., S.,
Jacksonville, Fla.
- Clyde Connie Harrison, Jr.
502 Copenhill Ave., N.E.,
Atlanta, Ga.
- Carl Roerig Hartrampf, Jr.
2965 Howell Mill Rd., Atlanta, Ga.
- Arthur Roy Henderson
P. O. Box 1022, Florence Villa Sta.,
Winter Haven, Fla.
- Charles Mack Hendricks
1818 Jefferson St., N.,
Nashville, Tenn.
- Clarence Roy Hixon
525 Second Ave., Columbus, Ga.
- Robert Bryant Holloway
1048 Randle St., Memphis, Tenn.
- John Plummer Holt
5 Furman Ave., Asheville, N. C.
- Richard Giraud Horton
3128 Metropolitan, Dallas, Texas
- Edgar Vaston Howell, Jr.
11 Clarendon Pl.,
Avondale Estates, Ga.
- Deurward Lyeman Hughes
734 Pearson St., Greensboro, N. C.
- Gerald Edward Elliott Hughes
1344 S. Bronough, Tallahassee, Fla.
- Thomas Jefferson Hunt
317 Glenndale Ave., Decatur, Ga.
- Herman Wilbert Hyatt
963 - 37th Ave., North,
Nashville, Tenn.
- Cato Ray Ivey, Jr.
1645 Selma Pl., Macon, Ga.
- Robert Judson Jarrell
Greenville, Ga.
- Louis Lanier Johnson
NAS Corry Field, Pensacola, Fla.
- Stanley Emerson Johnson
1109 - 17th Ave., North,
Nashville, Tenn.
- Harris Quillian Jones, Jr.
1705 Willivee Dr., Decatur, Ga.
- Samuel Hovey Jones, Jr.
678 Moreland Ave., N.E., Apt. 9,
Atlanta, Ga.
- Warren Jeffrey Jones, Jr.
427 Ashland Dr., Augusta, Ga.
- Robert Earl King
P. O. Box 2632, 1027 - 8th St., East,
Bradenton, Fla.
- Charles Amon Lanford
Stone Mountain, Ga.
- Daniel Leon Lauray
Lincoln Hosp., Durham, N. C.
- Edward Raymond Leverett
231 Sisson Ave., N.E., Atlanta, Ga.
- Lawrence Kendrick Lewis
Siloam, Ga.
- Jack Barnes Lindley
Powder Springs, Ga.
- Francis Milton Lindsey
3296 Ridgeland Ave., Macon, Ga.
- John Elridge Littman
P. O. Box 262,
Tuskegee Institute, Ala.
- James Walter McCann, Jr.
762 St. Charles Ave., N.E.,
Atlanta, Ga.
- Glenn Edwards McCormick, Jr.
566 E. Taris Rd., Greenville, Ga.
- James Kenneth McDonald
Jackson St., Newnan, Ga.
- William Joseph McKenzie, Jr.
Rt. 3, Box 60A, Savannah, Ga.
- Julian Kelly McLendon
3015 Lumpkin Rd., Columbus, Ga.
- William Palmer McNair
Rt. No. 2, Wrens, Ga.
- George Brock Magruder
635 Terrace Blvd., Orlando, Fla.
- James Calder Major
984 Forrester Rd., N.E., Atlanta, Ga.
- Randolph Augustus Malone, III
1347 N. Emory Rd., N.E.,
Atlanta, Ga.
- John A. Maloof, Jr.
1559 Johnson Rd., N.E., Atlanta, Ga.
- Stephen Cuthbert May, Jr.
3551 Ivy Rd., Atlanta, Ga.
- Alva Louie Mayes, Jr.
297 Morton Ave., Athens, Ga.
- Frederick Troupe Mickler, Jr.
Box 328, Madison, Fla.
- Cecil LeRoyce Miller
Auburn, Ga.
- John Marvin Miller
4546 Verne St., Memphis, Tenn.
- Joseph Henry Miller, III
2227 Terrace Way, Columbia, S. C.
- Milton Brittain Moore, Jr.
2440 Berkeley Lane, N.E.,
Atlanta 6, Ga.
- William Bernard Mullins
Route 1, Mansfield, Ga.
- Byron Lamar Murray, Jr.
Sardis, Ga.
- DuBose White Murray
2583 Habersham Rd., N.W.,
Atlanta, Ga.
- Neal Hilley Newsom
1640 - 17th Ave., Columbus, Ga.
- Cola King Newsome
Rt. 8, Box 280, Ahoskie, N. C.
- Adan Nigaglioni
Headquarters, Branch U.S. Discip-
linary Barracks, Fort Gordon, Ga.
- Luceil Cooper Bauer North
Hamilton, Ga.
- James Edwin Outler
Warner Robins, Ga.
- Samuel Richard Owings, Jr.
Meharry Medical College,
Nashville, Tenn.
- Bernard Harry Palay
1687 Boulevard, N.E., Apt. D-4,
Atlanta, Ga.
- Theodore Gus Panos
Piedmont Hosp., Atlanta, Ga.
- Robert Alton Parrish, Jr.
2744 Washington Rd., Augusta, Ga.
- Tillman Elder Pearce, Jr.
3407 Fairway Rd., N.E., Atlanta, Ga.
- Arthur Jay Pearl
1695 Clifton Rd., N.E., Atlanta, Ga.
- Arthur Glasco Pettis
1595 Campbell Ave., Macon, Ga.
- Alpheus Maynard Phillips, Jr.
164 Country Club Rd., Macon, Ga.
- Felton Clyde Pilate, Sr.
Newton, Miss.
- Thomas Nelson Pirkle
R.F.D. No. 3, Box 87, Smyrna, Ga.
- Gerald Marvin Patock
344 W. Broad St., Savannah, Ga.
- Bernard Mayer Portman
1208 E. Victory Dr., Savannah, Ga.
- Ambrose Joseph Pratt
901 S. Main St., Martinsville, La.
- Walter Madison Presnell
609 Butler, Knoxville, Tenn.
- John Crayton Pruitt
261 Howard St., N.E.,
Atlanta 17, Ga.
- Harold Edward Ramsey
2413-B Jefferson St.,
Nashville, Tenn.
- William Joseph Rawls
2303 - 7th St., Columbus, Ga.
- Charles Dean Ray
1012 Bellevue Dr., N.E.,
Atlanta, Ga.
- Karl Heinrich Rist
State Hosp., Milledgeville, Ga.
- Robert George Rizza
602 E. Henry St., Savannah, Ga.
- Henry Allen Robinson, Jr.
2039 Ridgewood Dr., N.E.,
Atlanta, Ga.
- Donald George Rosenberg
987 Rupley Dr., N.E., Atlanta, Ga.
- Elaine Ross
781 Allendale Rd.,
Key Biscayne, Fla.
- William Tirsch Royal
Rt. 9, Box 295-A, Urbana, Ohio
- Milton Butler Satchez, Jr.
1771 Kissingbower Rd., Augusta, Ga.
- Philip Thomas Schley
1352 Peacock Ave., Columbus, Ga.
- Anderson Thomas Scott, Jr.
226 Queen St., Hampton, Va.
- Edgar Leonard Scott, Jr.
97 - 37th Ave., N.,
Chattanooga, Tenn.
- John Nathaniel Shearouse
Brooklet, Ga.
- James Howard Shinaberger
Madigan General Hosp.,
Tacoma, Wash.
- John Elias Skandalakis
St. Joseph's Infirmary, Atlanta, Ga.
- George Brook Skipworth
2932 - 17th Ave., Columbus, Ga.
- Ira Hunt Slade, Jr.
523 Kincaid, Griffin, Ga.
- Francis Jones Smiley
1402 East 31st St., Savannah, Ga.
- Henry Roy Smith, III
1215 Johns Rd., Augusta, Ga.
- John Orson Smith, Jr.
1234 Oxford Rd., N.E., Atlanta, Ga.
- Phillip Monroe Smith, Sr.
1415 Johnston, Nashville, Tenn.
- Glen Davis Sockwell
Rt. 3, Box 499, Tusculumbia, Ala.
- Peter Chris Sotus
Box 1057, Emory University, Ga.
- Wentford Abner Spears
864 Laurel Ave., Macon, Ga.
- Marjorie Louise Hudson Speight
127 Craner St., Hearne, Texas

New Heart Clinic in Dalton

ESTABLISHMENT OF A HEART CLINIC at Dalton was approved August 12, 1956, by the Executive Committee of the Georgia Heart Association at a meeting in Atlanta concluding the Association's annual tour of the state's 14 cardiac clinics.

The recommendation for a Dalton Heart Clinic for indigent patients was made by the Clinics Committee as part of its formal report on the tour. During the past two weekend periods, the committee made inspection tours of heart clinics at LaGrange, Columbus, Albany, Thomasville, Waycross, Brunswick, Jesup, Savannah, Macon, Augusta, Athens, and Atlanta.

Paul Reaser, Dalton, accompanied the committee on the second half of the tour and was present at the meeting in August. He presented a resolution adopted by the Whitfield County Medical Society expressing the need for a heart clinic at Dalton to serve Northwest Georgia.

Dr. Reaser said the new clinic would be in operation by October "at the latest." He said the main problem now is to make doctors in this area aware of the new clinic's existence and its services to indigent heart patients.

To be eligible for heart clinic treatment, a patient must be referred by a physician, and indigency must be certified by the welfare department of the county in which the patient lives, said Dr. Reaser.

The clinic will be open one day a week, and more frequently if the patient load should demand it later.

The Dalton Business and Professional Woman's

Club has expressed interest in providing drugs for patients who come to the clinic, Dr. Reaser said. This would be a great help toward the statewide problem of making drugs available for the medically indigent.

The founding of a heart clinic at Dalton is the result of the efforts of the Whitfield County Medical Society and Dr. Reaser, said Lamont Henry, Atlanta, Heart Association President.

Other Dalton physicians who have stated a willingness to serve in the clinic are Earl T. McGhee, James A. Redfearn, Jr., and John Looper. The clinic will be located at the Whitfield County Health Center.

Col. W. T. Johnson, chairman of the recently organized Whitfield County Heart Council, also expressed the need for a clinic in the Northwest Georgia area, and his continued interest in the Heart Association program contributed much toward the founding of the new clinic.

The Dalton Clinic will make the fifteenth heart clinic in Georgia established by the Georgia Heart Association. Facilities and technical equipment for the clinic are furnished by the GHA and the State Health Department.

The Clinics Committee was generally pleased with operation and procedures of the 14 clinics visited on the tour.

Arthur M. Knight, Jr., Waycross, committee chairman, said the patient load increase in the past year indicated the effectiveness of the clinic program in Georgia.

Physicians Licensed by Examination (continued)

Melvin Spira
3-D Country Club, Augusta, Ga.

Barbara Angier Stephenson
529 Collier Rd., N.W.,
Atlanta 18, Ga.

William Wallace Stewart
Meharry Medical College,
Nashville, Tenn.

Olden Edward Stinson
729 South 8th St., Griffin, Ga.

John Samuel Stone
1302 Morgan St., Tampa, Fla.

Maxwell James Sweat, Jr.
800 - 10th Ave., Albany, Ga.

William Steele Talley
636 Cumberland Rd., N.E.,
Atlanta, Ga.

Jack Etheridge Tanner
581 Gresham Ave., S.E., Atlanta, Ga.

Robert Franklin Taylor
1281 Burlington Rd., N.E.,
Atlanta, Ga.

Edgar Brown Thompson, III
Box 1347, Emory University, Ga.

Robert Franklin Thompson
23 College St., Newnan, Ga.

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William Nisbet Toole
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Atlanta, Ga.

Daniel Ray Turner
710 - 9th Ave., Albany, Ga.

Bayard Shields Tynes
Piedmont Hosp., Atlanta, Ga.

Frank Norman Vickers
P. O. Box 1007,
Emory University, Ga.

Ladislao Klein Wallerstein
1543 Groesbeck Rd.,
Cincinnati, Ohio

Henri Hudson Weathers, III
415 South 48th St.,
East St. Louis, Ill.

Charles Lewis Ridley White
2272 Miller Field Rd., Apt. 4,
Macon, Ga.

Sol White, Jr.
2498 Houston St., Beaumont, Texas

Thomas Conrad Williams, Jr.
218 Georgia Ave., Valdosta, Ga.

Thomas Wendell Williams
813 Spencer, Flint, Mich.

Kenneth Meldrum Wing
Box 90, Emory University, Ga.

John Henry Winston, Jr.
Route 3, Box 404, Montgomery, Ala.

INFORMATION

ANNOUNCEMENTS

Southeastern States Cancer Seminar—George Washington Hotel, Jacksonville, Florida, November 7 and 8, 1956. Meeting sponsored by Duval County Medical Society, under the auspices of the Florida Division of the American Cancer Society, Florida State Board of Health, and the Graduate School of Medicine of the University of Florida. No registration fee; room reservations may be made direct with the hotel. For information contact Dr. Harry W. Reinstine, Jr., Publicity Chairman, Cancer Committee, P. O. Box 4545, Jacksonville 1, Fla.

Fall Course in Gynecologic Endocrinology—New York University Post-Graduate Medical School, October 8-12, 1956. Tuition—\$125.00; course under direction of Dr. Herbert S. Kupperman, Associate Professor of Medicine. For further information write to Dr. Kupperman at N. Y. U. - Bellevue Medical Center, College of Medicine, 550 First Ave., New York 16, N. Y.

Interim Meeting of the Georgia State Obstetrical and Gynecological Society—Ralston Hotel, Columbus, Ga., November 16, 1956. This meeting is held in conjunction with the Alabama State Obstetrical and Gynecological Society and will open at 9:00 a.m. Guest speakers include Dr. Frank Whitacre, Vanderbilt University School of Medicine, and Dr. Jason Collins, Tulane University School of Medicine.

Urology Award—The American Urological Association offers annual award of \$1000 for essays on the result of clinical or laboratory research in urology. Competition limited to urologists who have been graduated not more than 10 years, and to hospital internes and residents doing research work in urology. For full particulars, write the Executive Secretary, William P. Didusch, 1120 North Charles St., Baltimore, Md. Essays must be in his hands before December 1, 1956.

Van Meter Prize Award—The American Goiter Association offers the award of \$300.00 and two honorable mentions for the best essays submitted concerning original work

on problems related to the thyroid gland. The essays should cover either clinical or research investigations, should not exceed 3,000 words, and must be presented in English. Duplicate typewritten copies, double spaced, should be sent to the Secretary, Dr. John C. McClintock, 1491½ Washington Ave., Albany 10, N. Y., not later than January 15, 1957. For further information, write to Dr. McClintock.

1957 Prize Essay Contest—The Council on Undergraduate Medical Education of the American College of Chest Physicians offers three cash awards (\$500, \$300, and \$200) to be given for the best contributions prepared by undergraduate medical students on any phase in the diagnosis and treatment of chest diseases (heart and/or lungs). For information and application form, write to the Executive Director, American College of Chest Physicians, 112 East Chestnut St., Chicago 11, Ill.

Postgraduate Courses on Diseases of the Chest—Hotel Knickerbocker, Chicago, Ill., October 15-19, 1956; and Park-Sheraton Hotel, New York City, November 12-16, 1956. Tuition for each course is \$75. Further information may be obtained from the Executive Director, American College of Chest Physicians, 112 East Chestnut St., Chicago 11, Ill.

American College of Physicians Postgraduate Courses—The following courses will be offered in the fall of 1956: Recent Advances in Cardiovascular Disease, Clinical Neurology, Internal Medicine, Recent Advances in Internal Medicine, Selected Problems in Internal Medicine, Gastroenterology, Electrocardiography, Pathologic Physiology of the Blood Dyscrasias. For information as to dates and location of each course, write to The American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa.

American Medical Writers' Association Meeting—Hotel Morrison, Chicago, Ill., September 28-29, 1956. Speakers include Dr. Dwight Murray, AMA President; Dr. Paul Dudley White, Boston; Dr. Richard M. Hewitt, Alton Blakeslee, Dr. Morris Fishbein, Dr. Austin Smith, etc. For further details, write to Dr. Harold

Swanberg, Secretary, 209-224 W. C. U. Building, Quincy, Ill.

American Rhinologic Society Annual Meeting—Illinois Masonic Hospital, Chicago, Ill., October 9-13, 1956. For information, write to Mrs. Mabel Campbell, Corresponding Secretary, 834 Wellington Ave., Chicago 14, Ill.

Fiske Essay on Infertility—The Caleb Fiske Prize of the Rhode Island Medical Society will be given this year for the best dissertation on "The Present Day Treatment for Infertility." The paper should be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of \$350 is offered. Essays must be submitted by January 1, 1957. For complete information, write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis St., Providence 3, R. I.

Eighth Annual Meeting and Scientific Sessions of the Georgia Heart Association—General Oglethorpe Hotel, Savannah, September 14 and 15, 1956. No registration fee for physicians, interns and medical students. Reservations should be made directly with the General Oglethorpe Hotel, Savannah. The meeting is approved for Category I credit by the American Academy of General Practice. Speakers include the following: Robert Glover, M.D., Thoracic and Cardiovascular Research Laboratory, Presbyterian Hospital, Philadelphia; Steward Wolf, M.D., Professor and Head of the Dept. of Medicine, University of Oklahoma School of Medicine; William B. Schwartz, M.D., Assistant Professor of Medicine, Tufts College Medical School; Eugene A. Stead, Jr., M.D., Professor of Medicine, Duke University School of Medicine; and Noble O. Fowler, Assistant Professor of Medicine, Emory University School of Medicine. A panel, composed of all the visiting speakers, will be held as the last event of the session; Charles F. Stone, Jr., will act as moderator. Please send any questions that may occur to you in advance to Dr. Stone, 384 Peachtree St., N. E., Atlanta 8, Ga. A box will also be placed in the meeting hall to receive questions.

Georgia Tuberculosis Association and Georgia Trudeau Society Annual Meeting—Rome, Ga., September 21 and 22, 1956. The theme of the meeting is "The Patient, the Hospital,

and the Community." For information, contact the Georgia Tuberculosis Association, 33 Pryor Street, N. E., Atlanta 3, Ga.

International College of Surgeons Annual Congress—Palmer House, Chicago, Ill., September 9-13, 1956. For specific information about the program write to the Secretariat, International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, Ill.

Mississippi Valley Medical Society Meeting—Hotel Morrison, Chicago, Ill., September 26, 27, and 28, 1956. Details may be obtained from the Secretary, Harold Swanberg, M.D., 209-224 W. C. U. Building, Quincy, Ill.

DEATHS

WILLIAM POPE BAKER, Atlanta, died on July 11, 1956, at the age of 62. Dr. Baker lived at 979 Springdale Drive, N.E.

A native of Zebulon, he studied at Emory University, Mayo Clinic, and served his internship at Grady Memorial Hospital, Atlanta.

Dr. Baker was one of the first radiologists in Atlanta. He studied in Chicago under Dr. Charles Steinmetz, who helped to develop x-ray. Dr. Baker was active in the practice of medicine until illness forced him to retire 20 years ago.

He was a member of the Glenn Memorial Methodist Church and the Shrine.

Survivors include his wife; his mother, Mrs. W. B. Baker, Atlanta; and a daughter, Mrs. Paul Kirk, Atlanta.

VIRGIL CLYDE DAVES, Vienna, died July 12, 1956, at a Macon hospital. Dr. Daves had been ill for only two days.

Born at Blue Ridge, Ga., Dr. Daves was a graduate of Atlanta Medical College, now Emory University School of Medicine. There he was a member of the Alpha Kappa Kappa medical fraternity. Forty-two years ago he came to Vienna to practice, and for 25 years he was county physician. He was a member of the Vienna Baptist Church, a Mason, and Shriner.

Dr. Daves served several terms as state representative from Dooly County and one term as senator from the 14th senatorial district. He

had also served as mayor of Vienna in recent years.

Funeral services were held at the Vienna Methodist Church; burial was in the City Cemetery. Among those serving as pallbearers were the following physicians: W. R. Baker, Hawkinsville; M. L. Malloy, J. T. Christmas, V. M. Waters, and Lee Waters.

Surviving Dr. Daves are his wife, the former Miss Henrilea Gross, Alamo; a daughter, Miss Virgie Diane Daves; a brother, H. H. Daves, Vienna; and two sisters, Mrs. J. E. Phillips, Douglas; and Mrs. J. C. Deady, Atlanta.

"On February 28, 1956, **HENRY LAZARUS LEVINGTON** departed this earth after having lived a very busy life, until his retirement a few years before his death. The regret over the passing of so prominent a doctor remains with us, and the vacancy which he has left in the community is apparent from day to day.

"Henry Levington was born in Savannah and was educated in our public schools, graduating from Savannah High School in 1910. As a youngster, he was a member of Chippewa Square which, 50 years ago, meant a great deal to the boys of the city. He received his pre-med course from the University of Georgia and earned his M.D. there in 1918, then interned at the Savannah Hospital, the present Warren A. Candler Hospital. He began the practice of medicine after this, and shortly took his place among the more skillful physicians and surgeons of his native city.

"He had an alert and probing mind, and was a student of both medicine and the classics. He was devoted and loyal to his family, and little less so to his many friends and patients.

"Outside of his family, friends and patients, his chief interests were his church, the University of Georgia, and the Georgia Medical Society, of which he was president in 1933. Since its revitalization a few years ago, he was one of the first life members of the Board of Trustees of the Endowment Fund of the Georgia Medical Society, and at the time of his death, was president of this Board.

"He contributed regularly and generously of his time and money to all of his interests and was a shining example of loyalty and duty.

"Therefore, be it resolved, that by

the death of Henry Lazarus Levington the Georgia Medical Society has lost one of its most efficient and devoted members, whose first thought was always "Does this proposal help our Society and Savannah."

"Be it further resolved, that copies of these resolutions be spread on the minutes of the Georgia Medical Society, and that a copy be forwarded to his family as an acknowledgment of the privilege of associating with him as a friend and co-worker, and of our appreciation of him as a citizen and physician."

FLETCHER ADRIAN SMITH, 56, Elberton, died July 14, 1956, at his home. Funeral services were held the following day at the Ricks Funeral Home, and burial was in Westview Cemetery in Atlanta. Among the pallbearers were J. S. Jenkins and Carey Mickel.

Dr. Smith was born in Tennessee and came to Elberton in 1919 to work before going to medical school. He practiced medicine in Elberton for 26 years.

Surviving Dr. Smith are his wife, the former Miss Nell Wilson; and a brother, William Lawrence Smith, of Buffalo, West Virginia.

PIERCE LEE WILLIAMS, Cordele, died on July 9, 1956, at the age of 68. Dr. William had been ill for two weeks.

Dr. Williams was one of Crisp County's most active and well known physicians; he had practiced medicine in the county for 43 years. For half that many years, he was county physician. He was associated in practice with his cousin, L. E. Williams, who graduated with him from the old Atlanta Medical College in 1913.

Dr. Williams is a past president of Crisp County Medical Society and the Third District Medical Society. He also served as a member of the Crisp County Board of Health. He was a member of the Primitive Baptist Church, the Masons and the Shrine. He also served for a short time, in 1949, as head of the Milledgeville State Hospital.

Dr. Williams is survived by his wife, the former Miss Lollie Brown; and three sons, P. L. Williams, Jr., M.D., Jack G. Williams, both of Cordele, and Dan E. Williams, Albany; and a daughter, Mrs. F. M. Farris of Ocala, Fla.

Funeral services were held at the Primitive Baptist Church, with burial in Sunnyside Cemetery; physi-

cians and druggists of Cordele were honorary pallbearers.

SOCIETIES

Members of the GLYNN COUNTY MEDICAL SOCIETY have set up an endowment fund for the purposes of promoting the health of Glynn County by providing items needed locally which are not available at the hospital or health center, and for advancement of medical knowledge and education. The fund was started with a gift from Mr. Alexander Calder, director of Union Bag and Paper Company, which amounted to \$5,000.

PERSONALS

First District

John R. Harrison has recently come to Millen to open his office for the practice of medicine. His office will be located in Lee's Clinic on the corner of College Avenue and Gray Street. Dr. Harrison completed his internship in June at the Macon Hospital.

JABEZ JONES, medical director emeritus of Telfair Hospital, Savannah, has recently agreed to serve as temporary administrator of the 70 year old institution. Dr. Jones will serve in this capacity until a successor to Miss Markham, superintendent until September 1st, is found.

Dr. and Mrs. GEORGE W. MEYER, Metter, have returned to their former home in Chapel Hill, N. C., after spending two years in Metter. Dr. Meyer will specialize in orthopedic surgery in Chapel Hill. Taking his place is George Dame, formerly of Jacksonville, Fla., who will occupy the offices vacated by Dr. Meyer.

Second District

Martin Bailey, Cairo, has recently opened his office for the practice of medicine in Cairo. A native of Harlem, Ga., he received his B.S. degree from the University of Georgia and graduated from the Medical College of Georgia in 1955. He interned for a year at Athens General Hospital. Dr. and Mrs. Bailey and their son Lee are residing in the Lester Coleman Apartment on Fifth Street, Cairo.

GEORGE R. DILLINGER, Thomasville, stressed the danger of self-administration of "miracle drugs" at a meeting of the Professional

Nurses' Club of Thomasville recently. Dr. Dillinger said that although these drugs now give help to patients who a few years ago had little chance of recovery, they often cause harm if not administered under the supervision of a doctor.

Dr. and Mrs. H. K. HEATH, formerly of Homerville, are now residing in Pavo where Dr. Heath is engaged in the practice of medicine. Dr. Heath attended North Georgia College and the Medical College of Georgia. He interned at St. Mary's Hospital in Athens. Dr. Heath is a member of the Alpha Kappa Kappa Medical Fraternity, the Southern Endocrine Society, and Thomas-Brooks Medical Society.

Third District

Dr. and Mrs. MAURICE ARNOLD, Hawkinsville, announce the birth of a daughter on July 9, 1956, at Macon Hospital. She has been named Florence Pauline.

Fourth District

EDWIN JORDAN CALLAWAY, Covington, has been appointed chief of the Newton County Hospital staff, of which has been a member since the hospital's opening in 1954. Dr. Callaway is a graduate of Emory-Oxford and the Emory University School of Medicine. He interned at Lawson General Hospital and did graduate work at the University of Michigan. A veteran of World War II, he served three years with the U. S. Army Medical Corps in both the European and Pacific Theatres. Dr. Callaway is also on the staffs of the Rockdale County Hospital, Conyers; Jasper County Hospital, Monticello; and the Walton County Hospital, Monroe.

The newly organized National Guard Medical Unit in Griffin spent two weeks in training at Fort Stewart this summer under the command of Lt. Colonel SAMUEL J. DEFREESE, Monroe. The company is designated as the 117th Surgical Hospital (Mobile Army).

WILLIAM B. FACKLER, LaGrange, chief of the LaGrange Heart Clinic, addressed the LaGrange Lions Club at a recent meeting. His subject was heart disease and the work of the Georgia Heart Association in the state.

G. B. FISHER, Franklin, announces the association with him in

the practice of medicine of Robert M. West of Salisbury, N. C. Their offices are in the Heard County Memorial Hospital. Dr. West is a graduate of the Medical College of Georgia and interned at Crawford W. Long Memorial Hospital, Atlanta.

Norman P. Gardner, Thomaston, announces the opening of his offices at 101 Avenue F in East Thomaston for the practice of general medicine. Dr. Gardner is a graduate of the Medical College of Georgia and received his undergraduate training at Emory University. He is married to the former Miss Jeanne-Marie Farrar of Macon; Dr. Gardner is a native of Madison.

T. A. SAPPINGTON, Thomaston, fractured his leg when the horse he was riding collided with another horse. This kept him down for only a few days, however, and then he returned to his practice at just about full steam.

JAMES M. SKINNER, Covington, announces the opening of his office for the private practice of medicine in Griffin. Dr. Skinner will limit his practice to obstetrics and gynecology. A graduate of Emory University, Dr. Skinner received his M.D. degree from the Medical College of Georgia in 1952. He interned at University Hospital and served three years as resident in obstetrics and gynecology at the University Hospital and Macon Hospital. He is a member of Phi Beta Kappa, Alpha Kappa Kappa Medical Fraternity, Alpha Omega Alpha Honorary Medical Society. His office is located at 1241½ West Poplar Street, Griffin.

Fifth District

C. L. DAVIS, Roswell, announces the association with him in the practice of medicine of Warren F. Brown, who recently completed his residency at Grady Memorial Hospital, Atlanta. Dr. Brown, a native of Tennessee, received his pre-medical training at Vanderbilt University.

T. E. McGEACHY, Decatur, has announced that CHARLES WARREN DAVIDSON is now associated with him in the practice of medicine at 520 Church Street, Decatur. Dr. Davidson is a native of Lithonia and a graduate of Emory University School of Medicine. He interned for a year each in the VA hospitals in Boston, Mass., and Atlanta. Before

becoming associated with Dr. McGeachy, Dr. Davidson was chief medical resident at Emory University Hospital.

HAL M. DAVISON, Atlanta, President of the Medical Association of Georgia, was sworn in on July 10th as a member of the State Medical Education Board by Governor Marvin Griffin.

A. HAMBLIN LETTON, Atlanta, took cancer as his subject when he spoke before the Cobb County Unit of the American Cancer Society at a recent meeting in Marietta. He advocated the "oyster approach" to cancer—in other words, people should do something about cancer when it enters their lives as the oyster does something about the sand when it enters its shell—and the result is a pearl.

Sixth District

GEORGE H. ALEXANDER, Forsyth, suffered a heart attack when he was in Jacksonville, Fla., vacationing in July. Dr. Alexander was hospitalized in the Baptist Memorial Hospital there for a short while and is now back in Forsyth and has resumed his practice. Our best wishes for a speedy and complete recovery.

Reid Gullatt, Cochran, has opened offices at 110 East Dykes Street for the private practice of medicine, it has been announced. Dr. Gullatt is a native of Cochran. He and Mrs. Gullatt and their four children live in the old Dr. J. M. Smith house. Dr. Gullatt was recently the guest speaker at a meeting of the Cochran-Bleckley Business and Professional Woman's Club. He spoke on health and safety.

WILLIAM H. HOLDEN, Macon, has been elected president of the Holden Foundation Aeronautics, scientific organization. WILLIAM L. BARTON, Macon, and CLAUDE PENNINGTON, Macon, are on the board of directors. On July 28th, Dr. Holden left for a six weeks air exploration tour to Nova Scotia and the northern part of Canada.

JOSEPH PRITCHETT, Monticello, recounted the highlights of his trip to Nassau and the Bahamas for the Monticello Kiwanis Club. He illustrated his talk with slides and pictures made by him and his wife.

He concluded his program with a humorous record of a citizen's experiences in Florida and Nassau.

The construction of a modern office building to house the offices of several doctors has been announced by OTIS WOODS, Milledgeville. The building will be located on Cobb Street a short distance from the new Hill-Burton Hospital now under construction. Other physicians sponsoring the building are C. B. FULGHUM, E. Y. WALKER, and H. R. CARY. The four doctors now have their offices in the Richard Binion Hospital, which will be closed when the new hospital is opened.

O. C. WOODS, Milledgeville, has been named president and chief-of-staff of the new Hill-Burton hospital in Milledgeville. WILBUR M. SCOTT is vice-president, and CURTIS F. VEAL is the secretary. The following will also serve on the medical staff of the hospital: CHARLES B. FULGHUM, E. Y. WALKER, HOWARD R. CARY, JAMES E. BAUGH, HENRY DAWSON ALLEN, EDWIN W. ALLEN, T. C. JORDAN, J. F. BODDIE, and A. M. BODDIE.

Offices for the general practice of medicine have been opened by ROBERT M. WYNNE, Macon, at 2305 Ingleside Avenue, following completion of his internship and residency at the Macon Hospital. Dr. Wynne is a native of Macon; he received his A.B. degree from Emory University and his M.A. from the University of Georgia before taking his medical training at the Medical College of Georgia.

Seventh District

L. G. GARRETT, JR., and G. M. PATTILLO, Austell, moved into their new office building in July. The building is located at the corner of Love and Walker Streets, Austell, and contains a lab, operating room, business office, an office for each doctor, recovery rooms, treatment rooms, and five bathrooms. The building is to be called the Garrett Memorial Diagnostic Clinic in memory of the late LUKE GARRETT, SR.

J. S. KALEY, Smyrna, has opened his office for the practice of surgery at 126 Sunset Avenue, Smyrna. A native of Bremen, Dr. Kaley comes to Smyrna after two years of practicing in Marietta. He is a graduate

of Union University, Jackson, Tenn. He interned at State University, Iowa City, Iowa, where he also received four years' surgical training. Dr. Kaley served with the U. S. Navy from 1947-1949 and saw service at Oakland (California) Naval Hospital; Guam Naval Hospital, and the Palau Islands.

Miss Patricia Lee Finch was married to William Henry Lucas, Jr., Cedartown, on August 2, 1956. Miss Finch is a graduate of the St. Francis Xavier School of Nursing and is at present on the staff of St. Joseph's Infirmary. Dr. Lucas received his A.B. degree from Emory University and his M.D. degree from the Medical College of Georgia. He is now associated with his father, W. H. LUCAS, in the practice of medicine in Cedartown.

On July 8th, W. P. SMITH, Bowdon, was honored at a 90th birthday dinner party. Thirty-five members of his family were present for the celebration. Dr. Smith was graduated from the Medical College of Georgia in 1891 and has continued to practice medicine since that time. In 1941 he received his 50 year pin from the Medical Association of Georgia.

July 25, 1956, was declared "Smith and Wilson Day" in honor of W. P. SMITH, SR., and L. E. WILSON, both of Bowdon. The physicians were special guests at a picnic to which all the citizens of Bowdon were invited.

Eighth District

William A. Dickson, Nashville, announces the opening of his offices for the private practice of medicine in Nashville. He will share offices with JAMES S. PETERS on West Washington Avenue. A graduate of Duke University, he received his M.D. degree from the Medical College of Georgia, graduating in the class of 1954. He interned and served his residency at Macon Hospital.

JOSEPH B. MERCER and W. O. INMAN, Brunswick, announce the association in the practice of medicine with them of Jesse Lindsey Hunt. Dr. Hunt is a native of College Park, and he graduated from the Medical College of Georgia; he has just completed his internship at DePaul Hospital in Norfolk, Virginia.

J. A. LEAPHART, Jesup, has resumed his practice in Jesup after closing his office to spend several weeks at Sea Island on the advice of his physician.

Miss Patsy Avery was married to ROBERT EUGENE MILLER, Jesup, in August of this year. Mrs. Avery is a recent graduate of the Druid City Hospital School of Nursing, and Dr. Miller is a graduate of the University of Maryland School of Medicine. He interned at Baltimore General Hospital before coming to Jesup to practice.

Colonel PAUL H. MILTON, a native Georgian, has been named commandant of the Fort Stewart Army Hospital in Waycross. Col. Milton was born in Thomasville and has called Waycross his home for over 40 years. He has served in the Army from 1933 to 1939, 1940 to 1946, and from 1949 to the present. A 1919 graduate of Georgia Military College and a 1928 graduate of Emory University Medical School, Dr. Milton served originally with the Navy—from 1920-1922 and from 1928 through 1930. Col. Milton is a member of the American Medical Association and the American College of Surgeons.

Roy Ray, Folkston, is now on the staff of the McCoy-Jackson Hospital. Dr. Ray, a graduate of the Medical College of Georgia in 1953, served his internship at Macon Hospital and practiced in Alma for 19 months. He comes to Folkston from Florida where he served as health officer for Baker and Nassau Counties from February to July 1956.

W. W. SHARPE, Alma, introduced the featured speaker, Mr. Herman Talmadge, at the dedication of the new Bacon County Health Center in July. Dr. Sharpe is chairman of the Bacon County Board of Health. Also on the dedication program was S. C. RUTLAND, Atlanta, director of local health organization

of the State Department of Health.

Ninth District

GEORGE H. BOYD, JR., Clayton, has two new physicians associated in practice with him; they are Raymond D. Evans and Cecil Toole, both general practitioners. Dr. Evans is a native of Cleveland and interned in Miami, Fla. He is a graduate of the Medical College of Georgia. Dr. Toole is a native of Belvedere, S. C., and attended Emory University School of Medicine.

S. A. Harris, Buford, was the guest speaker at a recent meeting of the Buford Lions Club. Dr. Harris told the members assembled about the State Aid Program for medical students which he himself attended medical school under. Dr. Harris is one of the first of the graduates under this plan to begin practice in a small community of Georgia, having set up his practice in Buford only in July.

C. J. Walker, Gainesville, is now associated in practice with R. T. CAIN at 203 Sycamore Street. A native of Albertsville, Ala., he took his pre-medical training at the University of Alabama and graduated from Emory University School of Medicine in 1953. Dr. Walker interned at Fitzsimmons Army Hospital, Denver, Colo., and spent two years at Fort Benning in the U. S. Army Medical Corps. He and Mrs. Walker and their three children live on River Bend Circle in Gainesville.

Tenth District

V. P. SYDENSTRICKER and W. Knowlton Hall, Augusta, have received \$7,407 from the Department of Health Education, and Welfare for research on supplementary effects of various nutrients. H. D. Wycoff, Augusta, has been awarded \$2,763 for research on the synthesis and function of plasma fibrinogen. Dr. Wycoff is assistant professor of biochemistry and assistant professor of oncology. The Medical College of Georgia has also been awarded a

grant of \$50,621 for virus research, prevention, and treatment of after-effects of polio and support of respirator centers. This grant was made by the National Foundation for Infantile Paralysis.

Morris N. Dalton, Hartwell, has opened his office for the practice of general medicine in the Hailey Building, Hartwell. Dr. Dalton is a graduate of the University of Georgia and received his M.D. degree from the Medical College of Georgia. He interned at Greenville General Hospital, Greenville, S. C., before coming to Hartwell. Dr. and Mrs. Dalton and their daughter, Vickie, live at 109 Athens Street.

BRIGHT McCONNELL, JR., Augusta, has opened an office for the practice of orthopedic surgery at 1477 Harper Street, Augusta. A native of Augusta, Dr. McConnell attended Richmond Academy, received his pre-medical training at the University of Michigan, and was graduated from the Medical College of Georgia in 1950. He served his internship in a Tacoma (Washington) hospital and was resident in surgery at the VA Hospital in Columbia, S. C. He completed his residency training in orthopedic surgery at Augusta's University Hospital, and for the last 18 months he has been stationed at Ft. Gordon Army Hospital as chief of the orthopedic surgery service. Dr. and Mrs. McConnell and their three children reside at 1310 Buena Vista Road.

FRANK C. STORY, JR., Augusta, has opened his office for the practice of obstetrics and gynecology at 1417 Gwinnett Street. Dr. Story is a native of Augusta and a graduate of the Medical College of Georgia, class of 1952. He interned at Columbus City Hospital, and has been in residency training at University and Talmadge Memorial Hospitals for the past three years. Dr. Story resides at 2275 Darlington Drive, Augusta.

Injuries from power lawn mowers are apparently being seen in increasing numbers by many physicians. In addition to being painful and disabling, many of these injuries have caused loss of life, limb and eyesight. In an attempt to ascertain as accurately as possible the magnitude of this problem in Georgia, the Home Safety Divi-

sion of the Georgia Department of Public Health, in conjunction with private physicians, surveyed approximately 100 physicians during August.

Results of this sampling test will be used to determine whether or not a more extensive survey should be conducted. It is hoped that all interested physicians will cooperate in this study.

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Journal OF THE MEDICAL ASSOCIATION OF GEORGIA

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Photo by Ted F. Leigh, M.D.

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Rx for Democracy — Vote!

The most priceless ingredient of democracy is your vote. Physicians, both as citizens and leaders of the community, must set the standard—by exercising the sacred American right of voting in every city, state, and national election. The General Election will be held TUESDAY, NOVEMBER 6, 1956. You are eligible to vote in the General Election if you have registered during the past two years. Even though you may not have voted in the recent primary election held in Georgia, you are *still eligible* to vote in the General Election. Government by the people can only succeed through ballot, and ballot depends on people fulfilling this responsibility through their vote. The real success of any election is best measured by the number of votes cast which ascertain the will of the electorate, no matter who has been elected. November 6, 1956—General Election—Vote and be counted as a true citizen worthy of freedoms and still free to vote.

MAG Insurance Plans

Two major items of concern to the MAG Insurance and Economics Committee are "Office Overhead Insurance" which is income tax deductible and "Major Medical Insurance" which is sometimes called catastrophe insurance. Office Overhead Insurance would allow for monthly benefits (\$200 to \$1,000) to fit specific needs based on your business expense such as rent, employees' salaries, electricity, heat, water, depreciation, etc. Benefits would be paid should you be disabled, and under the care of a doctor, for a month or more because of injury or sickness. The MAG is investigating plans of this nature to seek out the best for Georgia M.D.'s.

Also being investigated are the many types of major medical insurance now being offered the public. This catastrophic type of insurance coverage is aimed at "white collar" executives and has deductibles (similar to auto collision insurance) ranging from \$250 to \$1,000 for which the patient pays, and insurance covers the rest to a limit of \$5,000. MAG feels that a plan of this nature might be of certain benefit to patients if rates are not prohibitive.

Scientific Exhibits

Physicians are urged to participate in the 1957 MAG Annual Session *Scientific Exhibits* section of the program. Ample exhibit space has been set aside for doctors wishing to present their scientific exhibits. The exhibits are given the best exhibit space available (separate from commercial exhibits), and prizes are

awarded the most educational exhibits. For Scientific Exhibit application forms, please write Dr. Ted F. Leigh, MAG Scientific Exhibit and Awards Chairman, Emory University School of Medicine, Emory University, Georgia, or the Headquarters Office.

1957 Annual Session

For your information, the MAG Council approved the scientific program for the 1957 MAG Annual Session, DeSoto Hotel, Savannah, April 28-May 1, Sunday, April 28—

1:30 p.m. to 5:00 p.m. SECTION MEETINGS:

(1) Pediatric, Orthopedic and Radiology Joint Section; (2) Surgery, EENT and Anesthesia Joint Section; (3) Neurology-Neurosurgery-Psychiatry Section.

5:00 to 7:00 p.m. MAG HOUSE OF DELEGATES.

7:00 to 8:00 p.m. MAG HOUSE OF DELEGATES SOCIAL HOUR.

Monday, April 29—

8:45 a.m. to 12:00 noon. GENERAL SESSION, "GP DAY".

12:00 noon to 1:00 p.m. GENERAL SESSION, BUSINESS.

2:30 p.m. to 5:00 p.m. SECTION MEETINGS:

(1) Obstetrics and Gynecology and General Practitioner Joint Section; (2) Diabetes and Medicine Joint Section; (3) Surgery and Pathology Joint Section; (4) Urology Section; (5) Radiology Section.

8:00 p.m. to 9:30 p.m. GENERAL SESSION, "GP DAY" RECONVENED.

Tuesday, April 30—

8:30 a.m. to 12:00 noon. SECTION MEETINGS:

(1) Surgery and Industrial Surgery Joint Section; (2) Diabetes, Chest and Medicine Joint Section.

12:00 noon to 1:00 p.m. GENERAL SESSION LECTURESHIP.

2:30 p.m. to 5:00 p.m. MAG HOUSE OF DELEGATES (2nd Session).

2:30 p.m. to 5:00 p.m. MAG ARRANGED PROGRAM.

Wednesday, May 1—

9:00 a.m. to 10:30 a.m. GENERAL SESSION, MEDICAL.

10:30 p.m. to 11:30 p.m. GENERAL SESSION, BUSINESS.

This represents the scientific side of the program only, and, though arranged, the specialty society luncheons and dinners, Alumni dinners, Social Hours and President's dinner are not shown.

MAG Journal

The *Journal of the Medical Association of Georgia* was awarded the American Medical Writers' Association Honor Award for Distinguished Service in Medical Journalism for "accuracy, clarity, conciseness and newness of information; for excellence of design, printing and illustrations, and for distinguished service to the medical profession." This plaque award was presented to the *JMAG* in the field of general medical periodicals (less than 3,000 circulation) at the 13th Annual Meeting of the AMWA on September 28, 1956, and was received by *JMAG* Editor Edgar Woody, Jr., Atlanta and Miss Frances Porcher, *JMAG* Managing Editor.

Journal of the Medical Association of Georgia, to further improve the standards of medical publications, is sponsoring a Southeastern State Medical Journal meeting November 3-4. Some 13 state medical associations are sending representatives, and attendance is limited to 30 medical journalists.

MAG Committee Chairmen Meeting

MAG President Hal Davison has planned a dinner meeting for all MAG committee chairmen to be held in late October or early November. Purpose of the meeting is threefold: (1) to honor and recognize the splendid activity of MAG committees; (2) to report on each committee's activity to date; and (3) to plan to advise on future activity for the completion of the 1956-57 year.

Attention GPs

One meeting that is a "must" for every general practitioner is the Georgia Academy of General Practice 8th Annual Session to be held at the General Oglethorpe Hotel, Savannah, Georgia, on October 17-18, 1956. An added attraction of this meeting is a refresher course (category 1 approved for 5½ hours) on "Office Management of Diabetes" sponsored by the Georgia Diabetes Association to be held immediately following the GAGP meeting—on Friday, October 19, also in the General Oglethorpe Hotel, Savannah. The GAGP Annual Meeting October 17-18 is, of course, category 1 approved for 10 hours.

Amendment to Medical Practice Act

Amendment to the Georgia Medical Practice Act, drafted by the Liaison Committee of the MAG and the Board of Medical Examiners has been approved in principle by both organizations and is now being worked on by MAG Committee on Legislation for introduction in the 1957 session of the Georgia General Assembly. This item represents a major effort on the part of the Board and the profession to strengthen existing laws regulating the practice of medicine.

Medicare, Public Law 569

The MAG, to implement Public Law 569 (Medical Care for Military Dependents), has appointed a Council committee to study arrive at a *normal* and *usual* fee schedule for Georgia physicians covering some 1,600 procedures (basically inpatient care) to be used for negotiation with the Department of Defense. The committee, composed of doctors from each district and each specialty, is collating material from specialty societies, and certain insurance fee schedules, etc., to recommend to Council. Final decisions will be made by Council both on the fee schedule and the fiscal agent to handle the actual operation of the plan with the last word on the matter up to the Department of Defense. Council will hold a special meeting in October to wrap up these details and appoint certain physicians to then negotiate this "last word" with the D.O.D.

Legal Council Retained

Per the 1956 MAG House of Delegates Directive, Council retained the firm of Alston, Sibley, Miller, Spann and Shackleford, Atlanta, to "study and advise the medical profession regarding the status of medical practice in the State of Georgia . . ." Attorney Francis Shackleford now has this study under advisement and investigation.

Automobile Safety

Council approved a luminous scotch-tape-like automobile bumper sticker bearing "M.D. in large letters, the MAG seal, and the slogan "drive safely" to be given each MAG member for placement on the member's automobile rear bumper. The sticker is permanent and designates the auto as belonging to a doctor of medicine who is a member of the MAG and further promotes the MAG auto safety campaign. Council also approved the publishing of a "new MAG member indoctrination" booklet both for present MAG members and new members. Purpose of the booklet is to provide information about the advantages of Association membership and explain the operation and structure of the MAG. It is believed that such a booklet will stimulate members to use the facilities, plans, and programs of the Association.

Membership Records

The MAG Headquarters Office has recently installed modern bookkeeping and membership record equipment in an effort to better serve Association members. A code system, keyed to the addressograph, is being used to designate type membership, status, and specialty. Under the 1956 revised MAG Constitution and By-Laws, classification of membership was altered to conform to AMA classifications, and with the new records equipment a more accurate and available system is in process.

The Use of Anticholinergic Agents in Peptic Ulcer Therapy

JOHN S. ATWATER, M.D., Atlanta, Ga.

MEDICINE HAS NEVER been considered a pure science, but rather it represents the application of many fields of endeavor with physiology, pathology, pharmacology, and the pure sciences contributing their influences. Thus, we speak in terms of the art and practice of medicine in contra-distinction to the more highly selective fields. The development of a physician under our present teaching system bears comment. In his academic years he is taught to delve into background material, and he dogmatically learns that the action of a drug is fairly specific. He learns how to measure the action of a drug. Despite this fact, in the clinical years with the actual handling of patients, his therapeutics seemingly disregards what his basic sciences have taught him. Somewhere a gap has developed between the basic facts and their clinical application.

Each of us is besieged by representatives of various pharmaceutical houses who wish to interest us in their particular antispasmodic or anticholinergic agents. Each representative implies, if he does not actually claim, that his product is highly effective, that it leads its field in acceptance, and that the published work of some investigator proves its clinical worth. On many occasions it is true that good pharmacologic and physiologic background substantiates these claims. Too often, however, the preliminary pharmaco-physiologic research is too limited in its scope and is applicable to only a small phase of the clinical problem. If the physician uses one of these products and the patient receiving the medication seems to improve, usually the clinical impression is that this product is excellent. It becomes a routine prescription until replaced by some other transient therapeutic triumph. The converse of this is also true. The failure of a product to help

the first few patients to whom it is given will prejudice the physician against it without further ado. Someone has quoted Henry Thoreau as saying "It is never too late to give up our prejudices. No way of thinking, however ancient, can be trusted without proof."

With the advent of the anticholinergic era, it has become necessary to analyze critically the therapy of patients suffering from peptic ulcers and especially those with duodenal ulcers. For many years we have been content to use atropine or tincture of belladonna as antispasmodic agents. Suddenly we are faced with a host of new compounds, basically quaternary amines in nature.¹⁻⁴

Neurophysiologic Concepts

Before discussing these compounds *per se*, it might be profitable to review briefly some of the neurophysiologic concepts that have paved the way for the synthesis of these medications. In fact, the work that has preceded our present knowledge was of sufficient importance to merit the award of the Nobel Prize.

Many years ago Loewi learned that if the vagus nerve were stimulated, the heart rate could be slowed. In brief, he did this while at the same time perfusing the heart muscle of a frog. He then took this perfusate and immediately perfused a second frog-heart preparation which had undergone vagal denervation. The identical slowing of the rate of this second heart occurred. The obvious conclusion was that something had been elaborated by the first heart after vagal excitation which was carried to the second heart by means of the perfusate. To say this in another way, vagal excitation caused the release of some chemical substance which, in turn, was capable of exerting the same vagal excitation effect despite vagal denervation. Later, this chemical substance was proven to be acetylcholine.

Interestingly, the release of such a chemical substance was not peculiar to the vagus nerve but occurred after the excitation of other parasympathetic post-ganglionic nerve fibers. Investigation of

1. The figures presented represent excerpts from the scientific exhibit on "The Evaluation of Drugs in Treatment of Peptic Ulcers: A Method of Study" by Atwater, John S.; Cayer, David; Oren, Benjamin C.; and Ruffin, Julian M., presented at the annual session of the American Medical Association, Atlantic City, N. J., 1955.

2. GRANTS: The exhibit was supported in part by a grant from the Lederle Laboratories Division, Pearl River, New York. The studies were supported in part by a grant from the Lederle Laboratories Division, Pearl River, New York and G. D. Searle Company, Chicago, Illinois.

the post-ganglionic sympathetic nerve fibers, in contrast to the parasympathetic ones, also revealed the release of a chemical substance which Dale named sympathin. This was quite different from acetylcholine and seemingly mimicked, if it were not identical to, adrenalin.

Autonomic Nervous System

Parasympathetic

Pre-ganglionic → acetylcholine
Post-ganglionic → acetylcholine

Sympathetic

Pre-ganglionic → acetylcholine
Post-ganglionic → sympathin

Figure 1

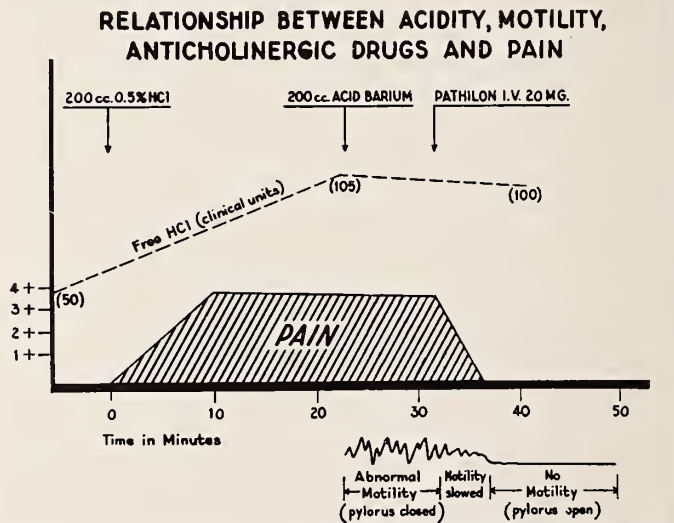
The next step was the exploration of the pre-ganglionic fibers and their synapses. It is known now that acetylcholine is released at the pre- and post-ganglionic endings of the parasympathetics and at the pre-ganglionic synapses of the sympathetic nervous system. Sympathin is elaborated at the post-ganglionic effector sites, their actions may not be

The implications of these early discoveries have become great, particularly in reference to the current concept of the action of anticholinergic drugs. It can be anticipated that the drugs acting on both systems should have identical action as far as the pre-ganglionics are concerned. Such has proven to be the case. By the same token, since sympathin is elaborated at the sympathetic post-ganglionic effector sites, and acetylcholine at the parasympathetic post-ganglionic effector sites, their actions may not be identical.

If stimulation of a nerve will cause release of acetylcholine at the ganglia and at the effector sites as in the parasympathetics, we may define such a nerve as being cholinergic in action. Any drug that blocks the effect of stimulation of such parasympathetic nerves, or the effect of acetylcholine if supplied directly to the end organs, may be defined in turn as an anticholinergic agent.

The important physiologic effects are concerned with two aspects, the effects on gastric acid secretion and on gastric motor activity. Much work⁵⁻⁹ has been done on the first of these, and, while the results are variable and not wholly dependable, the newer anticholinergic agents do suppress gastric acid secretion. The duration and degree of suppression varies from individual to individual. It is not uniform, and some patients evidence suppression for many hours although rarely do these drugs pro-

voke anacidity. On the other hand, the fairly consistent marked delay in gastric emptying time and in peristaltic inhibition attests to the anticholinergic effectiveness on gastric motility.¹⁰⁻¹¹ Of practical clinical importance has been the observation that, despite high levels of gastric acid secretion, if gastric motility be reduced, pain also will be alleviated. Abundant study is on record showing the presence of high gastric acid concentration in the stomachs of patients who were experiencing typical severe ulcer pain, such pain in turn being relieved almost immediately by the parenteral use of a potent anticholinergic drug.¹²⁻¹⁵ In fact, at times this observation has been used as a therapeutic test for ulcer pain differentiation.



55 patients with severe ulcer pain received Pathilon, 1-2 cc. q. 6h. parenterally. Immediate and complete relief of pain was observed in 44

Figure 2

Peptic ulcer is a chronic disease and the evaluation of drug therapy in any chronic illness is fraught with error. As pointed out by Kramer and Ingelfinger some years ago, there are several ways in which the effect of an antispasmodic agent may be evaluated. One may utilize smooth muscle strips and laboratory animals. In their places these are of value but may give erroneous physiologic concepts when applied to man. Even the use of balloon studies give rise to faulty conclusions. The observation of patients on their clinical response to an anticholinergic is notoriously inaccurate. Seldom is such an observation objective in nature, and there may be numerous uncontrolled factors entering the picture.

Method of Study

However, prior to and since the release of these newer anticholinergic agents it was decided to attempt a so-called "double blind study"¹⁷ using a large group of patients. This was accomplished by a coordinated and cooperative effort in multiple medical centers. Each center supplied a sufficient number of patients to be of statistical significance. All patients were treated alike except that alternate

patients received either the anticholinergic agent or a placebo. The placebo was of similar size shape, color, smell, and taste to the anticholinergic agent. The "double blind study" was so named because neither patient nor investigator knew which was the trial drug and which was the placebo. The patients kept daily records of their symptoms, treatment was continued over long periods of time, and finally the statistical data was assembled and analyzed as impartially as possible.

The initial study was made with Banthine and the method of study was sufficiently successful that the same plan was extended to many other anticholinergic agents. The succeeding presentation will summarize the work on Banthine, atropine, Pathilon, and the placebo groups. A portion of this work is being presented for two reasons. The first is to present one method of doing a controlled clinical study. The second reason is to illustrate the clinical effectiveness of these drugs in patients with duodenal ulcers.

These studies were undertaken mainly to determine if prolonged treatment with adequate daily doses of some anticholinergic agent would

- (1) change the ultimate course of the disease,
- (2) prevent or alter the frequency of recurrences,
- (3) decrease the frequency and severity of individual attacks,
- (4) decrease the incidence of complications such as hemorrhage, perforation or obstruction, and lastly,
- (5) by virtue of these four factors, would the necessity for surgery persist.

There were 563 patients studied. Each patient had a clinically and radiographically proven active duodenal ulcer with a history of activity in the six months prior to the onset of the study. All patients were followed for an average of 12 months, and many were observed for a period of two years. Each patient received instructions in the ambulatory ulcer type of diet (a bland diet with six feeding schedule) and was given some type of antacid preparation at two hours intervals while awake. Patients with pyloric obstruction were excluded from this study.

The duration, frequency, and severity of ulcer symptoms were determined in every patient, and on this basis the patients were divided into three groups, that is, those with mild, those with moderate, and those with severe ulcer symptoms.

The antacids employed were those commonly prescribed. In the Atlanta group Gelusil and Maalox were used with excellent results. Banthine, atropine, and Pathilon were the drugs studied. The average daily dose of Banthine was 400 milligrams, of atropine 1.6 milligrams, and of Pathilon 125 milligrams.

By using a card index system, a daily record was

kept of the number of tablets taken, the presence of ulcer distress, and the appearance of any side effects or other symptoms. Patients were usually seen at monthly intervals and appropriate follow-up X-ray studies were carried out. The final evaluation was based on the data recorded on these index cards and the clinical impression of the investigator which was recorded at the time of each follow-up visit.

On this basis each patient was classified according to his clinical status while he was taking the drug and this status was compared to his condition before beginning the study. Six categories were employed and defined as follows:

- (1) Symptom-free, those patients who had no ulcer distress throughout the period of observation.
- (2) Markedly improved, those patients who were symptom-free for the major portion of the observation period.
- (3) Moderately improved, those patients who were distinctly better in spite of periodic recurrences.
- (4) Slightly improved, those patients who felt that they were somewhat better, but continued to have their usual recurrences.
- (5) Unchanged, those patients whose clinical course was unchanged during the period of observation.
- (6) Worse, those patients whose clinical status became progressively worse, who developed complications, or who required surgery.

The patients in the first three categories were classified as those who showed good to excellent results. The other three groups were considered to show fair to poor results. It was arbitrarily decided that a recurrence should include some or all of the following: first, the recognition on the part of the individual of his usual ulcer distress lasting for a minimal period of five days consecutively, secondly, the development of some complication such as hemorrhage or perforation, and thirdly, definite X-ray evidence of increased ulcer activity.

Results

As is noted in Figure 3, 75 per cent of the patients receiving Banthine showed good to excellent results as compared with 53 per cent good results for those taking atropine. Fair to poor results were observed in 25 per cent of the patients taking Banthine in contrast to 47 per cent fair to poor results in patients taking atropine. In the Pathilon group 74 per cent showed good to excellent results with 26 per cent showing poor results. Thus, the Banthine and Pathilon results were comparable. Using the placebo, 48 per cent had good to excellent results whereas 52 per cent had fair to poor results. Thus, there was very little difference between the results obtained by

RESULTS

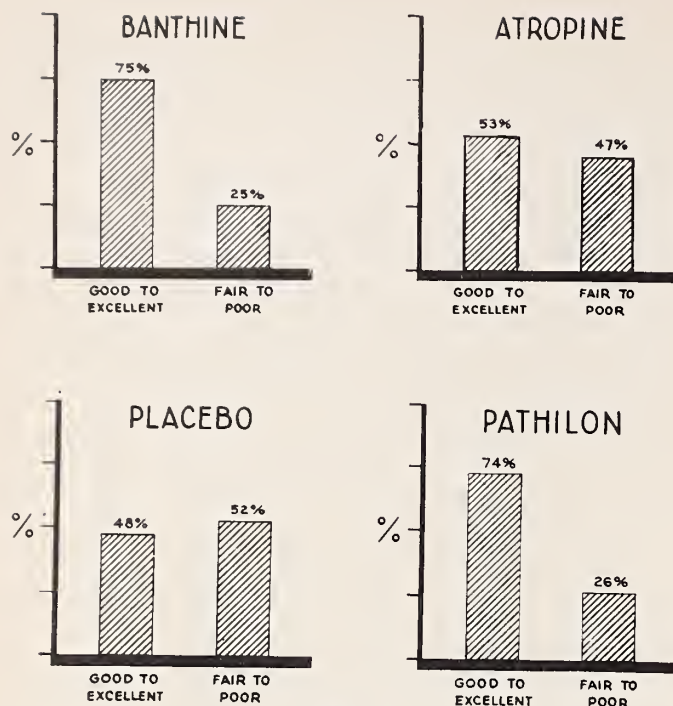


Figure 3

On Figure 4 the frequency and severity of recurrences are recorded. It will be noted that in the the atropine group and the placebo group. It is also obvious that the results in those patients receiving Pathilon and Banthine were significantly better than those receiving atropine or a placebo. It was interesting to note that patients who had mild ulcer symptoms responded much better to the Pathilon and Banthine than to atropine or the placebo. In the group with severe ulcer symptoms, there was practically no difference in response to Banthine, Pathilon, atropine or the placebo.

RECURRENCES

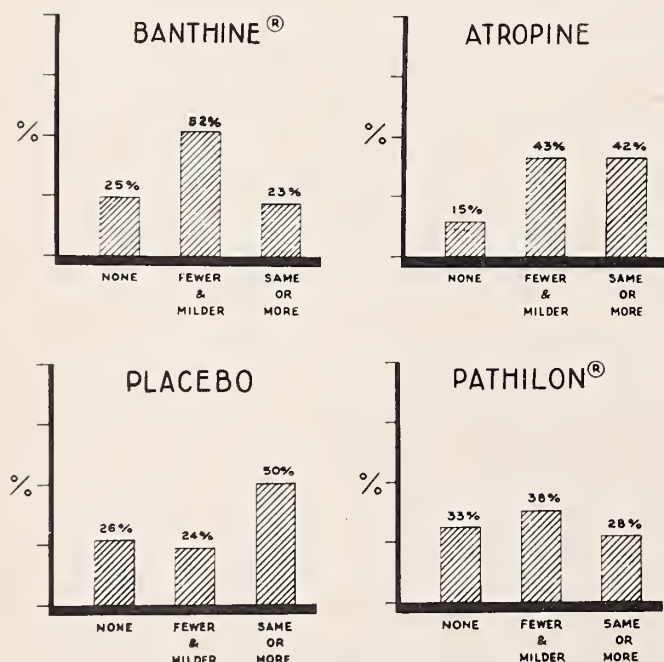


Figure 4

Banthine group 25 per cent had no recurrences, 52 per cent had fewer or milder recurrences, and 23 per cent had the same number or more recurrences than prior to treatment. On the other hand, with atropine only 15 per cent had no recurrences, and 43 and 42 per cent respectively had either fewer and milder or the same or more recurrences. Similarly when Pathilon was used, 33 per cent had no recurrences, 38 per cent had fewer or milder recurrences, and 29 per cent had the same or more recurrences than they had had prior to the onset of treatment. With the placebo 26 per cent had no recurrences, 24 per cent had fewer or milder recurrences, and 50 per cent had the same or more recurrences. Once again, it will be seen that patients taking Pathilon or Banthine had significantly fewer or milder recurrences than those receiving atropine or the placebo.

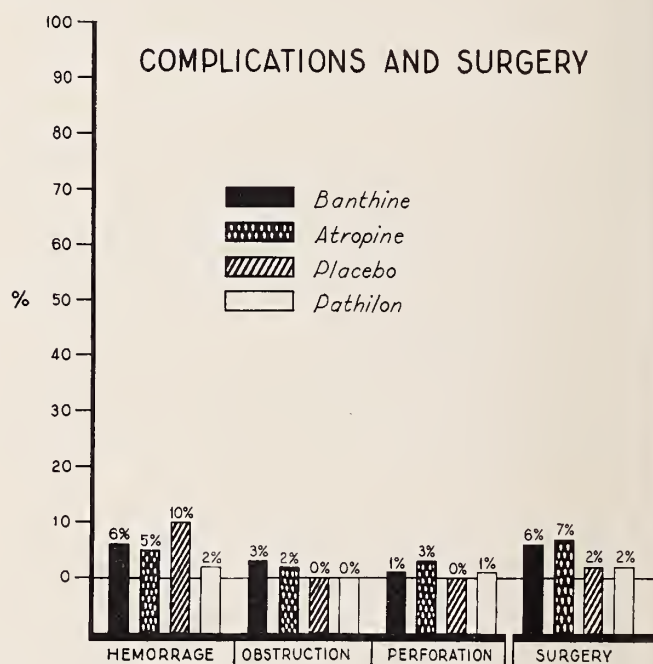


Figure 5

The incidence of complications and the incidence of those patients who needed surgery is found in Figure 5. There is no statistical difference between the various treatment groups. The incidence of perforation and of obstruction was small in all groups. Surgery was required in two to seven per cent of patients in the various groups. Thus, we did not feel that the use of any of these preparations materially influenced the occurrence of complications.

In Figure 6 there is presented the occurrence of side effects of the four preparations used, namely dry mouth, disturbance in vision, urinary retention, and stomatitis. Eighty-six per cent of all patients receiving Banthine, eight per cent receiving Pathilon, 4.3 per cent receiving the placebo, and 62 per cent of the patients receiving atropine had the dry mouth reaction. A similar proportion was noted for visual

disturbances. No urinary retention or stomatitis occurred using Pathilon, whereas 16.79 per cent of patients receiving Banthine had urinary retention and 8.38 per cent developed stomatitis. Of the atropine group 8.4 per cent developed stomatitis and 9.24 per cent experienced urinary retention. Thus, the statistical difference was most favorable with Pathilon. There was little difference between the use of the placebo and Pathilon as far as side effects were concerned.

Summary and Conclusion

From this study it is shown that significant symptomatic improvement occurred in duodenal ulcer patients treated with conventional ulcer management, supplemented by a good anticholinergic agent such as Pathilon or Banthine. This improvement was much better than when atropine or the placebo was used. However, the results seem weighted in favor of the milder or moderately severe cases. In these, improvement was uniformly good while in severe cases only mediocre results were observed. Significantly fewer patients had recurrences while taking one of the anticholinergic agents, but the recurrence rate was fairly high in all groups studied.

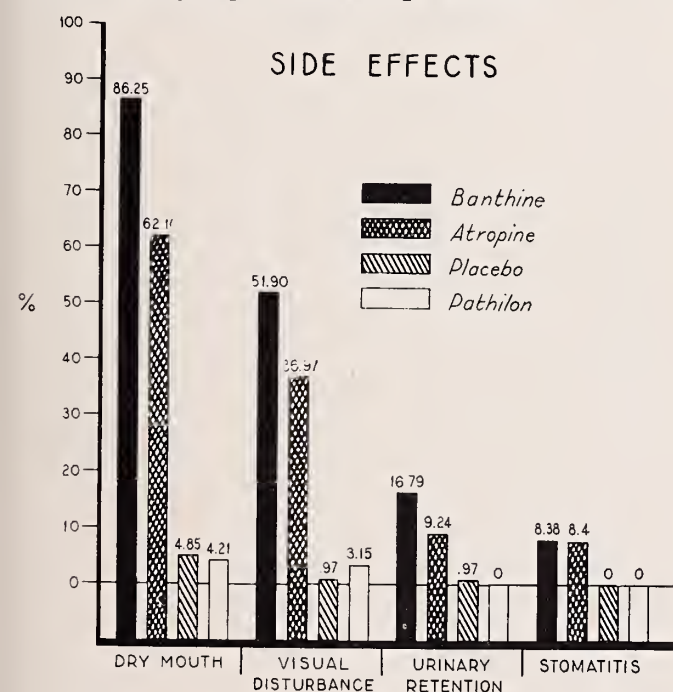


Figure 6

It was felt that despite the symptomatic improvement, the use of anticholinergic agents did not alter the eventual course of the disease pattern. This statement is based on three observations. The first is the fact that in many instances ulcer craters still could be demonstrated radiographically. The second is that the statistics revealed that complications still occurred. Lastly, there still remained the obvious need for surgical intervention at times.

Thus, the following conclusions seem justified:

- (1) A controlled study is imperative for the accurate evaluation of drugs in the treatment

of peptic ulcer.

- (2) Anticholinergic agents will inhibit motility and by this mechanism relieve ulcer pain.
- (3) A potent anticholinergic agent administered continuously to patients with duodenal ulcers affords better control than that received with the use of atropine or a placebo.
- (4) Recurrences and complications are not prevented by the use of these drugs.
- (5) Anticholinergic agents offer excellent adjunctive therapy. Basic conventional therapy, however, must still be employed to obtain good clinical results.

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Acute Arterial Injuries in Industry

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THE PROGRESS AND CHANGE that have occurred in the treatment of acute arterial injuries since World War II have been remarkable.¹ During this short 10-year period the treatment of arterial injuries by ligation has been replaced by routine re-establishment of vessel continuity.² Ligation of injured major arteries no longer has a place in the surgeon's armamentarium.

The channel of the injured artery may be reformed by one of several methods. A small laceration involving less than 15-20 per cent of the vessel circumference may be repaired by debridement and transverse arteriorrhaphy. The margins of the wound should be carefully debrided so as to remove all visibly damaged tissue. A small margin, 2.0 mm. to 4.0 mm. of apparently normal arterial wall is then excised, as damage to the arterial wall frequently extends beyond macroscopic detection. If the laceration involves more than 15-20 per cent of the involved vessel's circumference, or if the vessel is completely transected, continuity should be re-established by debridement and end-to-end anastomosis. If the anastomosis cannot be made without producing tension at the suture line, arterial continuity should be re-established by bridging the defect with an autogenous vein graft. Autogenous vein grafts are easily obtained from the saphenous and cephalic veins, and these grafts function well when used to replace segments of injured arteries in the upper and lower extremities.³ Vein grafts are not suitable for use in the aorta. Since most acute arterial injuries occur in extremity arteries, there is no need to worry about having an adequate supply of artificial or homologous arterial grafts on hand. The patient serves as his own mobile blood vessel bank.

Vascular surgery is difficult surgery. Anastomosing blood vessels is a time consuming and tedious procedure. Knowledge of established vascular techniques and experience with them are essential if patent vascular anastomoses are to be routinely obtained. Every surgeon who plans to treat vascular injuries should prepare himself in the laboratory, for the technic of vascular anastomoses must be perfected before attempting to repair injured arteries in humans.

Time is a most important factor in preventing

loss of an extremity which has suffered injury to its major arterial supply. Vessel continuity should be restored as soon as possible, preferably within the first eight hours following injury. Successful arterial anastomoses have been carried out as long as 72 hours following injury; however, the percentage of amputations is markedly reduced by carrying out reparative surgery as soon as possible.

With the rapid industrialization of the South, the yearly increase in traffic accidents and accidents in general, most of us will be confronted by patients who have sustained injury to a major artery. Any patient who has suffered trauma, particularly to an extremity, must be suspected of having an arterial, nerve, tendon, or bone injury until proven otherwise. We usually remember to obtain an X-ray examination, and to perform the routine tests for nerve and tendon injury, but all too frequently we overlook the possibility of damage to arteries. If the patient has a cold, white, mottled, pulseless extremity following trauma, the diagnosis may be simple. In certain instances the diagnosis can be made only by maintaining a high index of suspicion. It is not widely realized that injury to major extremity arteries may occur without immediate change in color or warmth of the extremity. It is even less widely known that pulses may be present distal to an arterial injury. When superficial wounds are sutured one must watch for evidence of injury extending to the underlying neurovascular compartment even though normal pulsations are present in the extremity. In addition, one must remember that arterial injury may occur secondary to closed fractures and blunt trauma. The region of the wound should be palpated for thrills and auscultated for murmurs even though the development of an arteriovenous fistula does not frequently occur in the early hours following injury.

Hemostasis can usually be maintained by using a pressure dressing. Accurate application of a hemostat to the bleeding artery may be possible in certain instances. Tourniquets are best avoided unless absolutely necessary. They should be removed as soon as other methods to control hemorrhage become available.

Patients who have arterial injuries may lose large volumes of blood, and the blood volume deficiency must be corrected before definitive surgery is considered. Salvage of life naturally takes precedence

From the Department of Surgery, Emory University School of Medicine and Grady Memorial Hospital, Atlanta, Ga. Presented at the 1956 Annual Session of the M. A. G.

Emory Will Present Postgraduate Sessions

FOUR POSTGRADUATE TEACHING sessions for practicing physicians and surgeons will be sponsored by the Emory University School of Medicine during the coming academic year. Designed to give thorough coverage to a few important segments of medicine, the sessions will be short—lasting two days—and intensive. The first session will be held October 19-20 on the Emory campus.

Subject for the October meeting will be *cardiac arrhythmias*. Liver disease, electrolytes, and common diseases of the blood will be discussed in December, March, and May, respectively. Visiting lecturers and physicians in the Atlanta area will take part in each session, according to J. Willis Hurst, director of the program.

Participating in the October session will be: Herman K. Hellerstein, of Western Reserve University,

and assistant physician of the University Hospitals of Cleveland; Robert P. Grant, formerly of Emory, now with the National Heart Institute at Bethesda, Md.; W. Proctor Harvey, of Georgetown University Medical Center, Washington, D. C.; Noble O. Fowler, R. Bruce Logue, Gordon Barrow, Walter Weigel, Paul Seavy, and Warren D. Stribling, all of Atlanta; and Calhoun Witham of Augusta.

The program will begin with registration at 8 a.m. October 19, with the first lecture, on "Normal and Abnormal Heartbeat," to be given at 8:40 a.m. by Dr. Hellerstein. The program will continue through Friday evening, concluding Saturday at noon. Registration is limited. A fee of \$20.00 will be charged for each session. Interns, residents, and other house officers will be admitted without charge.

Acute Arterial Injuries . . . (continued)

over salvage of limb. As stated before, injuries to major arteries are no longer treated by ligation. Major arteries are the main arterial trunks which are located proximal to the bifurcation of the brachial and popliteal arteries. If gangrene, amputation, and post-ligation functional ischemia are to be avoided, injuries to major arteries must be treated by re-establishing vessel continuity. Even though a more efficient collateral circulation is present in the upper extremities, continuity of injured upper extremity arteries must be restored if catastrophe is to be avoided.

Injuries to minor arteries—main trunks distal to the bifurcation of the brachial and popliteal arteries—may be treated by simple ligation. If both minor arteries in the forearm and leg are injured these vessels should be repaired, as a high incidence of gangrene follows ligation of both arteries. In practice it is possible to re-anastomose the radial, ulnar, and the anterior and posterior tibial arteries if careful technic is used.

Anticoagulants and sympathectomy are rarely necessary following arterial anastomoses. In an effort to prevent chronic venous insufficiency, attempts have been made to anastomose large veins which have been injured. Most vascular surgeons believe that anticoagulants are indicated following these most difficult of all anastomoses—vein anastomoses.

Penicillin is routinely used postoperatively, and, if indicated, streptomycin is added to the regimen. If thorough debridement of the wound is carried out, infection is not a common complication.⁵ Tetanus

toxoid or antitoxin is given as indicated. In an effort to maintain maximal circulation in the injured extremity it should be positioned slightly below the level of the heart. Unless concomitant fracture, or nerve or tendon injuries are present, the extremity is not splinted in a plaster shell. Most of these patients are allowed to ambulate the day following surgery.

Summary

1. Ligation of an injured major artery is inexcusable except under exceptional circumstances.
2. The continuity of injured major arteries can and should be re-established.
3. Injury to an extremity is sufficient in itself to suggest arterial injury. The diagnosis will usually be made if arterial injury is suspected.
4. Most vascular injuries which occur in industrial and traffic accidents, and in civilian practice in general, are ideal injuries to treat. It is not too much to expect that a 100 per cent restoration of arterial continuity should be obtained in these patients.

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Insulin Edema

DAN BURGE, M.D., Atlanta, Ga.

IN FEBRUARY 1954, a very unusual response to insulin was noted in a newly diabetic patient. Review of the literature failed to demonstrate an exact counterpart of the case—hence this report.

Sensitivity reactions to insulin are classified as local and systemic, with some cases showing both types.¹ The local reactions occur at or near the site of injection and consist of hot, red, tender, itching, indurated areas varying in diameter from one to six centimeters. These appear six to 12 hours after injection and may require three or four days to completely subside. Such reactions develop after each injection for three or four weeks and usually clear spontaneously. Changing brand or animal source of insulin often suffices to eliminate the problem. Protamine zinc insulin is more likely to induce such reactions than are other types.

Generalized urticaria and angioneurotic edema with stiffness of joints, nausea, vomiting, and diarrhea may occur, but less commonly than the local reactions. Insulin tumefactions and fat atrophy at sites of injection are also seen.² The causes of these latter conditions are unknown. Insulin resistance may be associated with insulin allergy.³

Griep⁴ reported rapid accumulation of anasarca (25-pound weight gain) in a 27-year-old female diabetic on starting insulin. With low sodium diet and diuretics the edema cleared within eight days, even though insulin was continued. Duncan⁵ describes insulin edema as a rare condition manifested as facial swelling, and occasionally edema of the extremities during the first few weeks of insulin therapy.

He states that usually no special management is necessary, although in one case salt was withdrawn from the diet for a few days and ammonium chloride was prescribed. This condition occurs chiefly in young females. Ant⁶ reports four cases of so-called "protamine edema" in diabetics on PZI. These were characterized by facial puffiness, slight dependent edema, increased blood cholesterol, creatinine and uric acid, low renal threshold for glucose, "dis-

turbed" serum albumin-globulin ratio, and moderate albuminuria. Hypertension developed in each of them. All of these signs cleared on changing to regular insulin and recurred on resuming Protamine Zinc Insulin. Subsequent to this report in 1949 no additional cases have been described.

Case Report

On February 9, 1954, a 27-year-old married woman in mild diabetic acidosis was seen. She gave a history of 20 pound weight loss, weakness, polyphagia, polydipsia, polyuria, irregular and excessive menstruation, during a period of six to eight months prior to February 1954. She gave no history of recent or frequently recurrent infection and none suggestive of diabetic neuropathy. Neither at this time nor later was history obtained indicative of cardiac, renal, or hepatic disease in the past. She had never had asthma, hay fever, or allergic eruptions prior to the treatment of her diabetes. The patient acknowledged that she was emotionally disturbed. She attributed this to domestic discord.

Pertinent features of the physical examination, on February 9, 1954, were temperature 99.2, pulse 82, blood pressure 110/70, respiration 16/minute and of normal depth. The patient was normally developed, thin, dehydrated, and appeared to be exhausted. Funduscopic examination showed no stigmata of diabetic retinopathy. A careful examination revealed no sign of cardiovascular disease. The liver was not enlarged, no spider angiomas were seen, nor was there any clinical evidence of portal hypertension.

On chest x-ray the heart appeared normal in size and contour. The lungs showed lesions compatible with old healed primary tuberculous complex, but no active parenchymal or pleural disease. Routine laboratory data were normal except for the following points: four per cent eosinophilia, urine specific gravity of 1.045 with four plus sugar, strongly positive acetone and diacetic acid. Fasting blood sugar was 358 mgm%. Protein-bound-iodine was 4.2 mcgm./100 ml., on March 3, 1954.

Acidosis was readily controlled with regular insulin and measures to restore hydration and electrolyte balance. She was discharged on the ninth hospital day receiving PZI 45u plus a small supplemental dose of regular insulin daily. Soon after discharge she was changed to NPH insulin. Her diet was 250 C, 75P, and 100F. On this regimen she increased in weight and strength.

During the first several days of insulin therapy she noticed small red, mildly pruritic, slightly raised plaques at the sites of insulin injection. These subsided after about two weeks. Within a few days she developed progressive facial and dependent edema. On February 17, 1954, she weighed 109 pounds. By March 26, 1954, she

From Department of Medicine, Emory University School of Medicine, Atlanta, Ga., and the office of Drs. Massee, Burge, & Brown. Presented at the 1956 Annual Session of the Medical Association of Georgia, Atlanta, May 1, 1956.

had gained 23 pounds, despite the low sodium diet and Neohydrin tablets one BID during most of this time, and three injections of Mercuhydrin 2.0 ml. each. On March 26, 1954, she exhibited three plus edema at mid-tibia bilaterally. Venous pressure was grossly normal. Blood pressure was 94/60, and pulse 10. Her liver was not detectably enlarged. Fluoroscopy of the chest gave no new information. Her diabetes was reasonably controlled. Urinalysis and PSP excretion were normal.

She took no insulin on March 27 and 28. On the morning of March 29 she weighed 126 pounds, a loss of six pounds in two days. She reported an impressive diuresis during March 28, 1954.

Resuming her former insulin schedule on March 29, her weight increased eight pounds in 48 hours.

Urine specimens taken before breakfast showed three plus sugar on March 30 and 31. During the following 18 days regular insulin, NPH, and PZI were used separately. During the use of each of these, she gained six to nine pounds, within 48 to 72 hours, and would lose a similar amount by diuresis on omitting insulin. During the next three weeks Crystalline Zinc Insulin and special beef-source NPH were tried. However, fluid accumulation could not be prevented on 200 mgm. sodium diet and Mercuhydrin 2.0 cc. IM three times a week. On omitting insulin she would promptly show marked glycosuria and, within four or five days, ketonuria. Antihistamine drugs were used by mouth and parenterally with the insulin without apparent effect. Total eosinophile count did not vary significantly with use and omission of insulin (range: 282 to 356).

In May, 1954, the patient consented to be studied for one week at Georgia Baptist Hospital. She could not afford to lose more time from her work, hence longer base line and follow-up observations were not possible. During this week total NaCl content of urine and volume were followed. Serum sodium and plasma chloride values were determined daily. They did not vary from normal. BSP retention of two per cent in 45 minutes and normal cephalin flocculation and serum protein studies had been previously found. Urine specific gravity was not "fixed" when aglycosuric. Microscopic examinations of several urine specimens showed no abnormal elements. Renal clearance studies were not done. During the study the patient received a diet containing the sodium equivalent of 5.0 gm., NaCl daily, and water as desired (see Figure 1).

The patient had received no insulin for four days

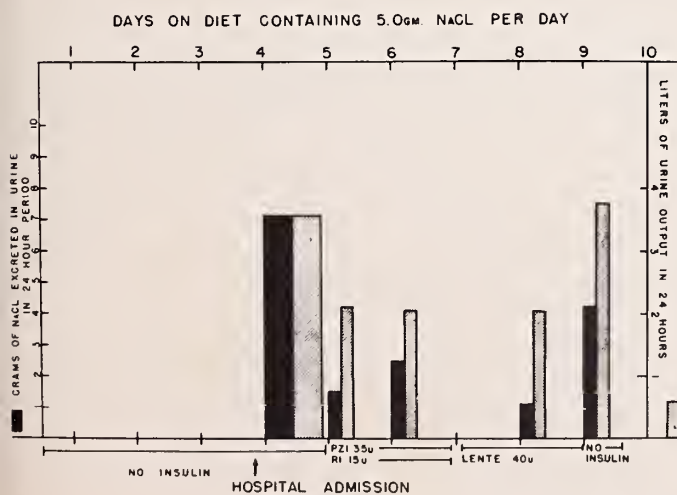


Figure 1

prior to hospital admission. Urine showed four plus sugar and strongly positive acetone, but no clinical picture of acidosis. During the first 24 hours collection period she excreted 7.2 gm. of NaCl and urine volume of 3600 ml.

The second 24-hour urine collection period followed administration of PZI 35 u and regular insulin 15 u. Total NaCl output fell to 1.8 gm., and total urine output to 2210 ml. The next 24-hour period on the same regimen yielded NaCl 2.7 gm., and urine volume of 2110 cc. At the onset of the fourth period Lente Insulin* 40 u was substituted for PZI and R.I. During this 24 hours she excreted only 1.6 gm. NaCl and 2.158 ml. urine. Insulin was omitted for the final collection period. Salt excretion rose to 4.3 gm., and total urine to 3725 ml. Fluid intake measurement was too inaccurate for interpretation. During this hospital study the patient was at no time on insulin therapy long enough to achieve control of her diabetes. It would have been desirable to determine NaCl excretion and urine output at height of fluid retention under controlled salt intake, but this was impracticable. This study was made at a time when the tendency to fluid retention had passed its peak. She was discharged on Lente 40 u daily, low sodium diet, and Thiomerin or Mercuhydrin 2.0 cc., IM as edema became uncomfortable—usually at 130 pounds body weight.

As an experiment, hydrocortisone was given 80 mgm. daily for five days. This was done with a realization of the adverse effect on diabetic control and on fluid retention to be expected from adrenal corticosteroids. Indeed these results were observed and none other.

Specific emotional upheavals adversely affected diabetic control, but did not noticeably affect fluid retention. No relation of severity of edema to menstrual cycle could be detected by the patient.

By July 1954 fluid retention was controlled by the diet and a mercurial diuretic injection about once or twice each week. Thereafter the tendency to fluid retention gradually lessened. Her last injection of a mercurial was on September 28, 1954.

During 1955 her face appeared puffy at times, but she had no appreciable dependent edema. Sodium restriction has been gradually abandoned since January 1956. In April 1956 24-hour urine specimens were obtained while on her Lente Insulin regimen, after three days without insulin, and during one day on regular insulin before meals. These are being preserved pending development of a financially practical method of aldosterone determination.

Discussion

The pathogenesis of this insulin induced edema is not clear. However, a number of deductions may be made. Unlike the cases of "Protamine edema," the fluid retention on insulin administration was independent of the type and source of insulin used.

An imbalance in osmotic pressure caused by withdrawal of glucose from the blood has been proposed as a cause of insulin edema.⁵ This explanation seems untenable. Glucose is a freely diffusable substance so that equilibrium should be re-established promptly. Since insulin acting at cell level would reduce cell glucose first, any transient shift of fluid

should oppose edema formation rather than favor it. In this patient the fluid retention began promptly on institution of insulin therapy, and persisted as long as it was given. The degree of edema was apparently unrelated to the adequacy of control of hyperglycemia.

Underlying organic disease of heart, kidneys or liver might be thought to have induced the edema except when prevented by glucose diuresis. When diuresis was checked by insulin therapy, edema would appear. Several points oppose this view. The patient gave no history of edema prior to onset of diabetes and insulin therapy. No symptoms nor signs of renal, hepatic, or cardiac disease could be elicited before or during this prolonged episode, and finally the tendency to fluid retention cleared although she has continued to use insulin.

The possibility of an endocrine mechanism is attractive. No overt signs of thyroid, ovarian, pituitary, or adrenal disease were found. Insulin administration might have induced elaboration of salt and water-retaining adrenal steroids. By what means is not indicated by any of the data obtained. An allergic basis is supported by the fact that typical allergic reactions occurred at the sites of insulin injection,

prior to the onset of evident fluid retention. If allergy played a part it must have done so by a mechanism involving sodium retention, perhaps by direct abnormal action on renal tubules.

Summary

1. Sensitivity reactions and previously described insulin edema have been reviewed.
2. A case is presented in which a newly diagnosed diabetic exhibited, whenever insulin was taken, severe fluid retention over a period of five months and to some degree for nearly two years.
3. Various possible modes of pathogenesis have been discussed.

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Doctors and Drug Firms

A FEW YEARS AGO, disturbing rumors began to drift through medical circles. There was collusion in prescription writing, it was said, between some doctors and some druggists.

The doctors were allegedly buying stock in local drug houses, then raking in "dividends" based on the number of prescriptions they wrote for the firm's products.

For a while the talk remained just talk. Then one day in 1952, a New York newspaper bared the facts—including names and addresses—on its front page. Whereupon the state's Attorney General moved in.

Before he'd finished, six drug firms were put out of business. Over 600 M.D.-stockholders in these firms lost their investments and varying parts of their professional reputations. Similar investigations were started in half a dozen other states. And medicine suffered another black eye.

That scandal has been buried. The public has probably forgotten it. But scandals are easily resurrected—as this one may well be:

Reports have reached us that doctor-and-druggist-owned pharmaceutical houses are springing up again

in such states as Pennsylvania, New York, Virginia, South Carolina, Texas, and Florida. Scores of doctors are being persuaded to buy stock in them and to serve on their board of directors.

Whatever their investment merits, these firms have one big strike against them: they tempt the doctor-stockholder to play favorites for financial gain in writing prescriptions.

He may resist the temptation. But in the eyes of the law he remains under suspicion—and doctors should be above suspicion.

Does this mean that a physician who owns stock in one of the well-established pharmaceutical houses should sell out? Of course not. The dividends he gets from such a company couldn't be affected by the prescriptions he writes. This point has been well expressed by a prominent New York physician who got entangled in the 1952 investigation:

"It's perfectly proper for a doctor to own the stock of a pharmaceutical company that's publicly traded on a recognized stock exchange. But for his own good, he'd better avoid unlisted drug stocks—or any drug stocks bought through private arrangement."

The Use of Intramuscular Chymotrypsin in Ocular Conditions

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THE EFFICACIOUS USE of trypsin in certain pathological conditions is now a well established fact, and dramatic results have been obtained with trypsin in many of these conditions. However, it is an equally well-recognized fact that the use of trypsin is not without some danger, particularly on the clotting mechanism of the blood. It is because of this that chymotrypsin is considered, in this paper, as the preferable therapeutic agent in ocular pathology where a therapeutic agent of this kind is required. A comparison of chymotrypsin and trypsin shows that they have sharply contrasting effects on clotting of normal rabbit plasma. Appropriate doses of trypsin cause clotting of oxalated plasma; chymotrypsin does not cause clotting at any concentration. Only in recalcified plasma could chymotrypsin, in a limited concentration range, cause a moderate acceleration of clotting; and under comparable conditions trypsin caused a rapid, complete clotting. With a purified prothrombin preparation, trypsin caused activation to thrombin but chymotrypsin did not. The important differences between trypsin and chymotrypsin of a qualitative nature are as follows:

1. On prothrombin, trypsin transforms prothrombin into thrombin. Chymotrypsin has more direct prothrombin activation in fibrin and clotting.
2. Trypsin will dissolve clots; chymotrypsin dissolves clots more rapidly and at a lower concentration.
3. On profibrinolysin, trypsin transforms profibrinolysin into fibrinolysin. Chymotrypsin has a like effect.

Procedure

All patients are given 2,500 units of chymotrypsin* (0.5 cc.) in sesame oil deep in the muscle every eight hours initially; and the interval is increased to 12 hours as soon as the patient begins to show the desired response. The duration of treatment must be determined individually in each case because the response to the drug will vary widely. The drug should always be used in a dry needle and syringe as the introduction of water will decrease the enzymatic potency of the drug.

Case Reports

Chymotrypsin was used in a total of 51 patients with various types of ocular pathology.

Extraocular Trauma (22 cases)

All of the cases in this group responded favorably to the use of chymotrypsin. The pain and swelling in all cases was markedly decreased in from 24 to 48 hours.

A 32-year-old Negro man was hit in the right eye with the butt of a pistol and did not seek medical attention until five days after the occurrence. When the patient was seen, the eye was swollen completely shut and was markedly edematous and extremely painful. The patient was started on chymotrypsin, and within 24 hours the edema had begun to subside, and the patient was free of pain. In 48 hours, the eye was completely open, and there was only subconjunctival hemorrhage. The patient was discharged on the fourth day with a completely normal eye.

Uveal Tract Inflammation (four cases)

All four cases showed a marked improvement within one week.

Case Report

A 32-year-old telephone employee had recurring uveitis for approximately six years. Vision at time of first examination was OU 20/300. Chymotrypsin therapy was begun, and definite improvement was noted on the fourth day when vision was found to be 20/60. In one week vision had improved to 20/40 where it has remained. Patient is now receiving one-half cc. of chymotrypsin each week as a prophylaxis.

HypHEMA (traumatic and post-operative) (five cases)

Improvement with the use of Chymotrypsin noted in all cases within 24 hours.

Case Report

An 11-year-old white child was struck in the eye with BB shots with massive anterior chamber hemorrhage resulting. Chymotrypsin therapy was begun and the eye put at rest. Diminution of hemorrhage was noted in 20 hours with complete clearing of the anterior chamber on the fourth day.

Case Report

A 71-year-old white man developed anterior chamber hemorrhage 48 hours after surgery for senile cataract. Chymotrypsin therapy was begun immediately, and hemorrhage began disappearing within 24 hours. Within 56 hours the eye was completely clear of hemorrhage.

*The material used for these studies was Chymar, supplied by The Armour Laboratories.

Typical Clinical Results

Woman with sty fistulized through conjunctiva of eye. Edema tremendous. Patient in great pain, eye extremely tender. Injection of 0.5 cc. of chymotrypsin three times daily.



24 hours after injection of chymotrypsin. Edema reduced. Eye slightly less painful.

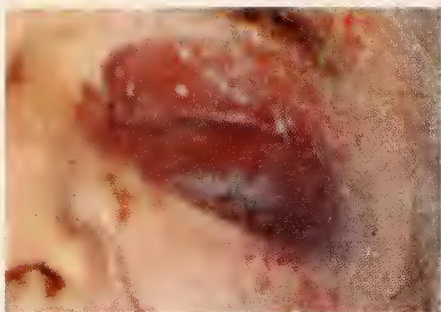


5th day after starting chymotrypsin. Very little swelling.

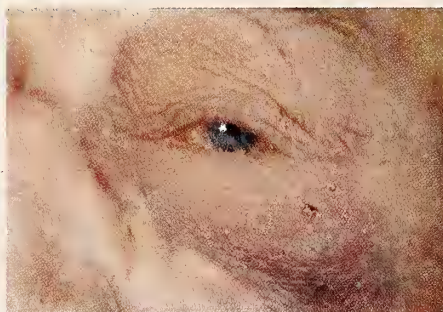


8th day. Only small amount of redness in conjunctiva. Lids normal. No swelling. Chymotrypsin stopped.

72-year-old hospitalized man fell going from his bed to bathroom. Struck eye on door knob. Chymotrypsin injected in 0.5 cc. doses every 8 hours. No other medication for this condition.



This picture made 4 hours after incident. Chymotrypsin started. Patient in considerable pain.



24 hours after 1st injection of chymotrypsin. Edema diminished, hemorrhage beginning to clear. Patient completely free from pain.



3rd day after starting chymotrypsin. Note marked reduction in swelling.



24 hours after starting chymotrypsin. Swelling beginning to diminish. Little pain.

8-year-old child fell while playing. Hemorrhage under skin—typical "black eye." 0.5 cc. of chymotrypsin injected twice daily.



36 hours after starting chymotrypsin. Patient completely free from pain. Hemorrhage and swelling diminished.

Vitreous Hemorrhage (three cases)

Two of the three cases in this group showed definite improvement within six weeks. Study is limited to hemorrhage of less than one year's duration.

Case Report

A 68-year-old diabetic white woman had massive vitreous hemorrhage of both eyes which occurred one week prior to observation. It was impossible to obtain a fundusoscopic view of either eye. The patient was given chymotrypsin, and within one week a visual acuity of 20/100 was obtained. Chymotrypsin was continued, and on the fourth week a vision of 20/40 was obtained. Patient had been given prophylactic doses of one-half cc. chymotrypsin in sesame oil weekly for seven months

with no occurrence of hemorrhage. Visual acuity has remained at 20/40.

Retinal Hemorrhage (two cases)

Results of treatment of both cases have not been of sufficient duration to report on at this time.

Diabetic Retinitis (seven cases)

Results of treatment of these cases have not been of sufficient duration to report on at this time.

Secondary Inflammation (five cases)

These five cases consisted of secondary inflammation due to retrobulbar neuritis (one case), acute dacryocystitis (three cases), allergic conjunctivitis (one case). Results in all five cases were quite satis-

A New Documentary Film About the Aged

"A PLACE TO LIVE" is a new documentary film about the aged. The film was produced to provide better understanding of this subject for the medical profession, gerontological groups and the public.

Findings based on a three-year research study by the Committee on the Aging, of the National Social Welfare Assembly, provided the necessary background information to produce this film.

"A Place to Live" is exceptional because it *honestly* portrays some of the problems concerned with old age, yet avoids any atmosphere of depression and despair. It is a picture within the bounds of actuality.

"A Place to Live" does not answer all the personal problems of older people but it *does* represent a step toward eventual solutions which can only come about through *continued research* and *proper planning*.

A PLACE TO LIVE: 16 mm, black and white, sound, showing time 24 minutes. Prepared by the Committee on Aging of the National Social Welfare Assembly, New York. Produced by Dynamic Films, Inc., New York. Procurable on loan from The Wm. S. Merrell Company, Geriatric Film Library, Cincinnati 15, Ohio.

... Intramuscular Chymotrypsin in Ocular Conditions ... (continued)

factory and showed definite response within one week. In the secondary manifestations from the allergic conjunctivitis, cortisone drops were used in conjunction with the chymotrypsin.

Diabetic Retinal Hemorrhage (two cases)

The visual acuity in both of these patients improved, and some improvement funduscopically was noted.

Case Report

A 42-year-old white male, a diabetic of long standing, was referred because of progressive loss of vision in the right eye. Visual acuity was 20/80 in the right, and 20/30 in the left eye. Chymotrypsin therapy was begun, and, after four weeks, the acuity in the right eye was 20/40 and the left eye was unchanged.

Intra-ocular Infections (one case)

One case of endophthalmitis was seen and treated with antibiotics and chymotrypsin with satisfactory results.

Case Report

A 47-year-old colored male was admitted to the hospital with a diagnosis of keratitis with secondary endophthalmitis. Five million units of penicillin were given every eight hours and oxytetracycline drops were instilled in the eye every hour for 24 hours, and then every two hours. Chymotrypsin therapy was begun at the same time. Treatment was continued for two weeks with a diminution of the infection and the patient was discharged from the hospital. Prophylactic use of chymotrypsin was continued for an additional two months.

Contraindications and Side Effects

Because of the nature of the drug there are no contraindications to its usage in patients with blood-clotting abnormalities. The only known contraindication is in patients who are sensitive to intramuscular injections of oily substances. This author, in two cases, has used chymotrypsin in known allergies where the ocular condition warranted drastic therapy, and results were satisfactory. Anti-allergic therapy

was instituted along with chymotrypsin. Two patients experienced general urticaria after the first week of treatment. Several patients have complained about pain at the site of injection, but it was not severe enough to interrupt the course of therapy.

Discussion

The exact mechanism of action of intramuscular chymotrypsin in reduced inflammation, edema, and pain has not yet been determined. Many theories have been advanced but none with enough evidence supporting them to be included in this paper. Its effectiveness, however, appears at this time to be beyond question as an adjunct to other recognized forms of therapy in ocular disease. This author, in many cases, particularly in extra-ocular trauma and hyphema, has used chymotrypsin without any other medication with satisfactory results. Where the ocular condition is of systemic origin, treatment of the underlying condition must, of course, be undertaken in order to obtain the desired results.

Summary

A comparison of the hemolytic action of trypsin and chymotrypsin has been made and the author concludes that the enzyme of choice is chymotrypsin.

Its use on various ocular conditions has been presented with case reports where indicated.

A series of 51 patients of various types of pathology are presented with the author's results.

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You, Doctor, Will Be a Witness

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LET US CONSIDER the subject of medical testimony and attempt to better the relationships between the physicians and attorneys in Georgia. From our work with the American Medical Association in the field of legal medicine, we realize that there are many problems which exist between the two professions which need serious and immediate attention. My remarks will be limited, however, to a brief review of the proper role of the doctor as a witness in court, what he should do, how he should act, what he can expect, and how the attorney can make that job easier and more comfortable for the physician and more effective for himself and his client.

In my work with the medical profession I have come to the realization that practically all doctors have an aversion to appearing in court and testifying in a lawsuit. Although a few have had unpleasant experiences as witnesses, most have been frightened by the exaggerated reports by a colleague of "murderous cross-examination" by an opposing counsel. For those of you who feel put upon by your role in litigation it may be some consolation to know that the Greek root or derivation of the word "witness" is "martyr".

There are, however, some basic reasons behind this aversion which deserve serious consideration. First, there is a fundamental difference in the method of approach of law and medicine so far as the discovery of truth is concerned. The lawyer attempts to maintain his position by argument and contention with opposing counsel. His life is one of advocacy of causes; his object is to magnify his own arguments and to belittle those of his opponent. The physician, on the other hand, does not live by contention. His training is in the free and open atmosphere of the laboratory, hospital, sickroom or private office. He demands full and frank discussion and disclosure of all phases of a case. All factors pertaining to the case are brought to light and evaluated. When all pertinent data are collected, he correlates them and forms a judgment with reference to the illness. By training and practice, therefore, the whole tempo and attitude of the day-to-day experience of the physician and lawyer are totally different.

In addition to being unfamiliar with situations

which to a lawyer are commonplace, physicians sometimes complain that they are practically made parties to the case in which they testify. It is often made to appear that the witnesses for the plaintiff are testifying against the defendant. This should not be true, of course. The witnesses should be impressed with the fact that they are testifying concerning a certain set of facts and should studiously avoid any appearance of advocacy.

Another reason for a doctor's hesitancy to act as a witness is his failure to understand the concept of examination and cross-examination. The general opinion of the average medical witness, when he has taken the witness stand, has taken an oath to tell the truth, the whole truth, and nothing but the truth, and has finished testifying, seems to be that while one attorney is trying to bring out the truth, the one on the opposite side is trying equally hard to keep the truth from being brought before the jury and court.

The physician dislikes the time that court cases take from his daily activities—and it is not because he fears he might lose a fee. Physicians today are very busy people with morning, afternoon, and sometimes all-night hours. The effect of stories about doctors cooling their heels in court for hours on end while lawyers argue seemingly obscure legal technicalities is very difficult to overcome.

The average physician's attitude toward a court appearance was summed up very well in a recent article published in the American Medical Association Journal. It stated in part:

"To the physician, the courtroom means wasting valuable time to give a carefully restricted opinion, necessarily based on inadequate observation, for persons who cannot understand the details of the problems and who probably will not believe him anyway."

To the physician who thinks this way, the "typical" trial lawyer is visualized as an oracle with a silver tongue, who delights in mortifying witnesses and who has a mysterious glamour that winds judges and juries around his finger. Fortunately this Perry Mason type exists almost exclusively in fiction and the movies. Physicians are amazed to find that most lawyers are quite human, with very normal reactions, such as respect for a brother profession, and are apt to regard physicians as their partners in a joint venture—the administration of justice.

Presented by Mr. Stetler, Director, Law Department, American Medical Association at the Annual Session of the Medical Association of Georgia, Atlanta, May 14, 1956.

Let me state then at this point that this is not all a one-sided picture. The lawyers also have their problems with the doctors. I wonder how many lawyers at some time or other have not had trouble in getting a medical report from an examining physician. Very few if any, I'll wager. Have they ever lost a case which seemed to cry for justice, but which could not be won because of the lack of proper medical testimony? Have they ever had a medical witness that played "hard to get" or one who wanted an exorbitant fee? Sure they have.

I believe that if physicians generally understood the importance of the medical report they would not refuse it or delay in supplying it. A doctor should be impressed with the fact that the medical report is the complete basis for the preparation and trial of the medical phases of the case. While perhaps no one knows with exactness, it has been estimated that from 50 to 60 per cent of all litigation involves personal injury. Most of these cases involve serious questions of fact concerning the alleged injuries of the plaintiff or claimant. In these cases the medical report is an absolute necessity.

In this same regard, physicians who have a dread of testifying in court, and that covers the majority, should be made to realize that a complete medical report will keep them out of court in nine out of 10 legal cases. Unfortunately, some doctors do not know what should be included in a complete medical report. First, identify the patient. Tell who gave the first aid, if any, and what it consisted of. The doctor should, of course, also show what his first and all subsequent examinations showed: the tests he performed; X-rays taken, the results thereof; consultations, with whom and the number; the treatment prescribed. His prognosis, his opinion as to the final outcome, and his opinion as to the causal connections, if any, between the accident and occurrence and the condition he now finds. The doctor should also show his estimated bill.

Since we all know that the things we fear most are the unknowns, I would like to suggest that the legal profession become more active in familiarizing the doctor with courtroom procedure and the "do's" and "don'ts" which should govern a medical witness. Maybe we could start out with some specific suggestions:

(1) Do not be afraid. There is no real magic about testifying. Just remember that a courtroom is a place where practical men are engaged in the serious work of endeavoring to administer justice. The honest physician who comes to court to tell the truth has nothing to fear.

(2) Don't testify as an expert unless you are satisfied that you are qualified in the area of specialization involved.

(3) Don't neglect to inform your patient's attorney of all unfavorable as well as favorable facts.

(4) Be courteous. This, of course, applies to all parties to the proceedings including the lawyers.

(5) Don't be smug. A jury is quite likely to react adversely to an attitude of this type. If you are an outstanding character or eminently well qualified, this fact will be apparent to the jury, probably through the efforts of your attorney. A modest attitude on the part of the witness is much more impressive.

(6) Tell the truth about reservation or exaggeration. This means too that a question should not be answered categorically in all instances. Often the proper answer should begin with an "if."

(7) Don't regard it as an admission of ignorance to indicate that your opinion is not conclusive. To do otherwise is frequently dishonest. Besides candor and frankness win respect and confidence.

(8) Don't use terminology which will not be understood by the jury, legal counsel, or the judge. The role of the witness is to explain not confuse.

(9) Don't lose your dignity. Remember that an attorney does not cease to be a gentleman because he questions you on cross-examination concerning your training, your experience, your integrity, your intelligence, or even your parentage. If his questions are irrelevant trust the court and jury to attach little significance to them.

To lose your temper and attempt to show him up will detract from your effectiveness.

Conclusion

Neither law nor medical science is static. Both grow daily, and as they grow each supplements the other. Despite our recent amazing progress, we of both professions have much to do. The fact that we realize and appreciate that each can assist the other is perhaps the first necessary step. The medical profession comes to us with its knowledge and information. We of the law bring to medicine our problems and hopes.

If you will permit me to do so I would like to close my remarks on a lighter vein. You will recall that earlier I referred to the necessity for the use of simple language by the medical witness. The failure of a witness to do this in an actual case aroused the poetic instincts of one writer, who in verse commented upon the testimony of the physician as follows:

With an erudite profundity,
And subtle cogitabundity,
The medical expert testifies in court
Explains with ponderosity
And keen profound verbosity
The intricate nature of the plaintiff's tort.

Discoursing on pathology,
Anatomy, biology,
Opines the patient's orbit suffered thus:
Contusions of integuments
With ecchymose embellishments,
And bloody extravasation forming pus.

A state of tumescence
Producing lacrimosity,
Abrasion of the cuticle severe,
All diagnosed externally,
Although he feared, internally
Sclerotic inflammation might appear.

The jury sits confused, amazed,
By all this pleonasm dazed,
Unable to conceive a single word,
All awed, they think with bated breaths
The plaintiff dies a thousand deaths—
What agony, what pain he had endured.

Said then the counsel for defense,
Devoid of garrulous eloquence,
Would I be correctly quoting you
To say his eye was black and blue.
To this the doctor meekly answered, "Yes."

535 North Dearborn St.

Hospitals Are Big Businesses

HOSPITALS ARE EXPECTED to be business-like. They have to buy equipment and supplies, and in that market place must act like other businesses. If their expenses regularly exceed their income, they must, like other organizations, go out of business. They have public relations problems, personnel problems, and board-versus-management problems similar to those which affect industrial organizations.

But the differences outrank the similarities. A manufacturer of fire-extinguishers will not sell you his product no matter how badly you need it, if you can't pay for it. But a hospital does not shut its doors in the face of an acutely sick man or a desperately injured one on that basis. The industrial executive can be measured by profits. The greater the gap between income and expenses, the greater the accolade given the manager. If a businessman can say that he operates on \$4 per item *per diem*, whereas the average is \$6, the businessman gets a pat on the back. But a hospital administrator does not boast of a low *per diem* cost.

The key man in rendering service in a hospital is the physician. And except in certain special situations, he is not paid by the hospital. This makes the hospital unique in the business world. In other non-profit organizations (schools for instance), there is the standard employer-employee status between management and the professional person rendering the key service. This establishes a very special relationship between staff and management in a hospital—as any one can see by comparing the teacher's attitude towards authority with the private practitioner's.

In business, the manager is usually a member—often an officer—of the board. In business, as strong managers develop, the boards become less influential. In hospitals, the administrator is an employee of

the board, hardly ever a member or officer in the usual sense. By reason of personality, some administrators of course are strong, and some board personnel are weak. But the general pattern is to have a board that definitely circumscribes the administrator's authority, at one end. The staff, in effect (if not in theory) circumscribes it at the other end. No industrial manager would last long—or want to last—under that arrangement.

A hospital dare not boast of profits, an industrial organization dare not boast of losses. The public will tolerate a strike of industrial employees, but never of hospital employees. Labor relations are thus something special in a hospital. The employees have none of the bargaining power that the strike weapon provides, though they may have acquired a power by reason of their scarcity. A business may have an occasional money-losing department as a sort of "loss leader," but this is exceptional. Every hospital has many money-losing departments, and it is often these very departments that give the hospital prestige. People often leave money to hospitals, seldom to businesses.

The hospital is more and more becoming an office for private practitioners. If this trend continues, the hospital will also be in the landlord business and this will further complicate the picture. Under those conditions, will the hospital demand the special privileges (tax exemption, for instance) it enjoys because it is *not* a business?

Medicine is becoming more hospital-centered. Doctors have an increasing stake in hospital health. It is, perhaps, natural to think of a hospital as a business—as a sort of hotel for sick people. But it behooves us to see that in a larger sense, whether we like it or not—indeed, whether *they* like it or not the hospital is not *a* business. It is your business—mine—and everybody's.

Reprinted from *The Journal of the Medical Society of New Jersey*, 53:351 (July) 1956.

Time and Surgeons

ONCE UPON A TIME, not too long ago, an orderly walked into the dressing room of one of our larger hospitals. "Sam," we asked, "how are Dr. X and Dr. Y getting along in Room 4?" Sam replied, "They's not operatin', Doctor, they's discussin'." When further questioned about just what he meant by that statement, Sam replied, "Well, one looks for a minute, and says this oughta go here, then the other one looks, and says no I believe it oughta go here. This goes on for awhile, then they work a few minutes, and then they has another discussion about what goes where and they're doin' more talkin' than they is operatin'."

Not too many years ago, the most successful surgeons were those who completed surgery within the shortest period of time. Speed was a necessity, since anesthesia, antibiotics, and fluid therapy were not as far advanced as they are today. Many surgeons feel (with recent advances in these three fields and with general improvement of post-operative patient care) that the amount of time they spend in accomplishing the surgical procedure is of little importance. Unfortunately, the result of this feeling is beginning to manifest itself in *needlessly* prolonged surgery.

One would expect a third or fourth year surgical resident to possibly take as long as a one and a half or even two hours to accomplish an appendectomy. But when one sees a supposedly accomplished surgeon, several years past residency training, routinely take this amount of time to extract a moderately inflamed appendix, then one wonders if possibly more emphasis might not be placed on expedient surgery than is being placed at the present time.

Although this statement is not statistically proven, except by consistent and frequent observation of post-operative patients over the past 10 years, it is felt that for every half hour that surgery is prolonged over a one hour period, one day is added to the patient's true convalescence. This is true in spite of the gentleness with which surgery is performed, or in spite of the skill with which anesthesia is administered.

Aside from the apparent lack of emphasis placed on the speed with which surgery is accomplished, there are other considerations which serve to prolong surgical procedures. Primary among these is the seeming amount of indecision that occurs in many

instances. It would seem to behoove any surgeon to plan what steps he shall take depending on the possibilities which he might encounter when the surgical field is entered. So often we see 30 or 40 minutes wasted in puzzling out a problem that could well have been solved quickly had some consideration been given to it prior to making the incision. Another instance in which surgery is prolonged occurs with the surgeon who cannot operate and talk at the same time. On many occasions an operation is stopped for three to five minutes while the surgeon lifts his head and delivers a lecture on some subject not relative to the patient at hand. This lecture may have to do with the most opportune manner of catching a trout, or of building a sailboat. At such times, the individuals supposedly in charge of the operation seem to forget that time does play an important part in the patient's recovery.

In addition to the above, there are many other factors which prolong surgery. There must be co-operation on the part of everybody at the operating table, down to the nurse who is circulating for the operation. Failure on the part of a suture nurse to have prepared adequately for the surgeon's desires can result in the loss of many minutes valuable to the patient.

We would by no means advocate that surgery return to the old days of "slash-bang", "pull and tug", and "rip and tear." However, we would urge that everyone associated with a surgical procedure give consideration to the factor of time, and do what he or she can to reduce the length of time spent in a patient's abdomen, chest, or on one of his extremities. Primarily, we would suggest that the present day teaching of surgery include in its training program a little more consideration for speeding surgical procedures, rather than emphasizing the fact that patients can be kept alive in spite of what appears to be a surgical marathon.

Whiplash Injury

THE SPRAINED NECK following an automobile accident — heretofore, a frequently ignored injury — steadily gains prominence in the practice of medicine. This is evidenced by the fact that in a metropolitan area containing one million people, each of two major insurance companies investigate 100 claims resulting from this injury yearly. One physician treats 60 such patients per year. Surely the

incidence can only increase with the development of more expressways, power brakes, and higher horse power—to say nothing of the increased volume of traffic.

A whiplash injury of the neck has many distressing potentialities. Early, it is difficult to recognize. Some 24-48 hours may lapse before signs and symptoms become significant. Late in its course, the patient may be considered psychoneurotic. Of striking importance is the fact that so frequently our professional brother, the attorney, is much more familiar with the expected changes than many physicians.

The injury results from forcible flexion of the cervical spine, following sudden acceleration of the head from a position of rest, then attending rebound with hyperextension of the neck. The most frequent cause (80 per cent) is an automobile accident in which the patient's car is struck from behind. As one might suspect, the most commonly affected group are those 30-50 years of age. Other etiological mechanisms include violent back slapping, slipping from a step or high curb, and clipping in football. Early (first 24 hours) complaints are limited to neck pain, mid-cervical posterior in location, and usually unilateral. Frequently there is associated occipital headache on the same side. Within 24-48 hours a characteristic group of symptoms rapidly develops. The patient notices limitation of motion for the head and neck, radiation of the headache to the temporal area, and extension of muscle pain up toward the occiput, to the mid-scapular area and frequently to the lower thoracic paravertebral muscles. In addition, wakefulness during hours of expected normal sleep may be expected, as well as irritability and emotional instability. A number of patients complain of "sore throat" and difficulty in swallowing. Others notice paresthesias, and some, pain and stiffness about the shoulder. Later, with the progression of symptoms, the patient (especially one untreated) may appear to be psychoneurotic. Also at this stage an underlying and pre-existing tension state may be aggravated.

Physically, one may anticipate variable changes. Limitation of the head and neck occurs. In the more severe injuries the patient may be seen supporting his head and neck with his hands. The examiner should look carefully for areas of muscle spasm and tenderness, particularly in the short extensor muscle of the neck and the trapezius. Frequently, "trigger areas," as well as visible segments of spasm are found in the involved musculature. The trapezius at

its lateral superior fold may be cord-like and contain palpable masses (fibrositis). Invariably, the neurological examination is normal.

X-ray studies are usually negative, or at most show straightening of the expected cervical curve. Rarely does a fracture exist. The diagnosis is actually facilitated by negative X-ray reviews. Pathologic changes are mixed and varied. One always expects muscle spasm. Frequently, avulsion, ruptures, or tears of the musculature occur with associated hemorrhage. There may also be distortion or disruption of supporting ligaments of the cervical spine. Cervical radiculitis sometimes results from edema and/or hemorrhage at nerve roots.

Treatment, of necessity, is individualized. For best results it must be instituted early. Heat, massage, active and passive exercise afford best results. Analgesics are usually necessary in the early period. Many patients also benefit from judiciously applied manual or mechanical traction. In many instances, mephanesin-derivative tranquilizing drugs ameliorate spasm and pain.

Because of the rapidly mounting incidence of whiplash injuries, certain features are of paramount importance for proper management. There is need for recognition of the extent and intensity of muscle spasm, as well as a thorough familiarity with ranges of motion in the neck and back. The desirability of early therapy, as well as the explanation to the patient of the expected progression of changes must be realized. One may expect the patient to develop apprehension, anxiety, and neuromuscular tension. The failure to elicit physical changes immediately after the accident should be discounted. Last, but not least, poor results from adequate treatment should throw suspicion toward the possibility of some underlying and pre-existing change (e.g. osteo-arthritis of the dorsal spine, etc.)

Neurodermatitis and the Nervous Patient

THE REPEATED LAMENT, "I am nervous" has become a widespread medical and social cliché, until it now seems to cover and excuse many of our diagnoses, as well as our mistakes in the manner of living. It colors the term "neurodermatitis" with something akin to opprobrium—as though it were a sin to scratch, because one itches. But man and animals have always scratched, for the most part to rid themselves of something, such as vermin, or a crust, or an inward compulsion, and even for pleasure. Neurodermatitis may result from a combination of both. First, to be rid of something, even a bad thought. Secondly, for pleasurable relief, often from an anxiety. Scratching becomes habitual, and one scratches because one itches, and one itches because

Cavalcade of Medicine

THE COBB COUNTY MEDICAL SOCIETY is sponsoring a Cavalcade of Medicine—a medical exhibition which is believed to be unique in the nation.

In effect, the event will be a medical convention for laymen, without speeches. It is free, and will be staged at the Larry Bell Auditorium in Marietta on November 11, 12 and 13, 1956.

E. P. Inglis and E. S. Marks, Marietta, co-chairmen, report that plans are almost complete for the display of x-rays, tissues, models, movies, and commercial and scientific exhibits assembled from throughout the state and nation.

Other medical exhibits have been open to the public, but Dr. Inglis said this will be unique in its size and variety, and many displays will deal with specific diseases, treatment, and equipment in which the public is keenly interested.

He said there is an increasing curiosity and need for better understanding of diseases and methods of treatment as shown by wide interest in newspaper and magazine medical columns and articles, and radio and television programs, such as "Medic" and "Medical Horizons."

The displays will represent 16 branches of medical service at Kennestone Hospital, Marietta, including internal medicine, surgery, obstetrics, dentistry, ophthalmology, radiology, and anesthesia.

Cobb County physicians, technicians, nurses, and also professional representatives of commercial pharmaceutical and equipment companies will attend the booths to explain the exhibits. Remer Clark, Marietta, is chairman of scientific and educational displays, and Robert Coggins, Marietta, is chairman of commercial exhibits.

There will be commercial exhibits by Eli Lilly; Parke, Davis; Endo; De Leon; Squibb, U. S. Vitamin;

A. S. Aloe; The Industrial Healthmobile; and Coca Cola. The list of allied exhibits is about complete; Red Cross, Polio Foundation, Lockheed, TB Association, Cancer Society, Heart Association, Civil Defense, Kennesaw Museum, *Today's Health*, Public Health, Mental Health Association. Four excellent exhibits have been obtained from the A.M.A.; Human Anatomy, Testing the Drinking Driver, Immunizations, and Safety in the Home. The emphasis has been on non-promotional, audience participation, interesting exhibits with a minimum of placard displays.

The educational exhibits will feature blood-typing, heart disease, cancer, mental health, alcoholism, herbs once used in Cobb County for medicine, industrial health, the American Red Cross, tuberculosis, polio, public health, safety, immunization, and Lockheed Aircraft Corporation's medical testing of pilots.

The auditorium stage will be converted into a modern operating room, with an adult-size dummy on the operating table. Free tests such as electrocardiograms and blood-typing, will be given to spectators.

The Woman's Auxiliary to the Cobb County Medical Society, headed by Mrs. E. P. Inglis, is doing a "saturation job" of publicizing the event through schools and civic clubs. Auxiliary members will assist in some of the booths.

Advisors and expeditors for the Cavalcade are Mr. Milton Krueger and Mr. John Kiser, Executive Secretary and Assistant Executive Secretary of the Medical Association of Georgia; Mr. Harold (Red) Palmer, President of de Leon Laboratories, Atlanta; Mrs. E. P. Inglis; and Mr. Ed L. Bridges, Executive Director, Better Health Council of Georgia.

Editorials (continued)

one scratches. Thus, the familiar vicious cycle seems to correspond to our cyclic manner of modern living, in which the inner compulsion repeatedly races in circles at an ever increasing pace. Somehow today we never seem to quite rid ourselves of the cyclic tax collecting, installment payments, and the recurring cyclic fear of insecurity, or apprehension.

Once there lived in the Great Smoky Mountains an old man. On his eightieth birthday, one of his sons, grown successful in the city, asked Pa to come to town. While there they passed a store in which a bunch of bananas hung, as usual, upside down. The old man stopped and looked intently at these

things, and asked, "What's them things, son?" His son said, "Pa, them's bananas. They taste right nice. Don't you want some?" After some moments of deep thought, Pa said, "No, son, I don't want any. I've got more wants now than I can afford to satisfy."

Could having more wants than we can afford to satisfy be the cause of some of this nervousness of which we complain? Socrates, before his death, said to his daughter, "I have nothing to leave to you save the hope that you will want nothing that you cannot have." The old man of the mountains knew how to prevent worry and nervousness. So did Socrates. It might be well for us to emulate them.





ACHROMYCIN*

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¹Posner, A. C., *et al.*; Further Observations on the Use of Tetracycline Hydrochloride in Prophylaxis and Treatment of Obstetric Infections, *Antibiotics Annual* 1954-55, pp. 594-598.



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The Heart In Myxedema

BERNARD L. HALLMAN, M.D., Atlanta, Ga.

THE MOST COMMON manifestation of heart disease produced by extreme hypothyroidism is pericardial effusion. The large hearts described in myxedema are usually produced in this manner. There is probably some degree of effusion in every case. The amount may be negligible and of no consequence. At the other extreme, cardiac tamponade may be present with venous engorgement, swollen liver, and other evidences of right-sided heart failure. This occurs very rarely. Usually the accumulation of fluid is gradual so that tamponade does not occur. The clear lung field in pericardial effusion is characteristic. If tamponade is not present, the heart size returns to normal with thyroid therapy, and a pericardial tap is not necessary. This effusion is usually of high protein content and is not associated with pericardial friction rub or evidences of pericarditis in the EKG.

Patients with myxedema may also have any heart disease known. Heart failure, enlarged hearts, and arrhythmias frequently are produced by pre-existent disease. Hypothyroidism predisposes to coronary atherosclerosis with all its manifestations. Thus angina and myocardial infarctions are common. Valvular disease, congenital heart disease, and all types of cardiac arrhythmias including auricular fibrillation may be present. The existence of hypertension is not only possible in myxedema but occurs in a slightly higher incidence than in euthyroid patients. There have been surprisingly few cases reported in which a "myxedema myocarditis" seemed to play an important role in producing clinical symptoms. This is in spite of the fact that microscopic edema probably occurs within the myocardium of all patients with true myxedema. Associated heart disease should be

looked for and expected in every case of myxedema.

The electrocardiogram is frequently abnormal in this disease. There is classically a sinus bradycardia with low voltage in all complexes, flattening of the T-waves, and not infrequently reduction in amplitude of the P-waves. Conduction delay effects are frequently seen. The low voltage is produced by a combination of factors: pericardial effusion, myocardial edema, emphysema, and edema of the chest wall. S-T changes do not occur with the pericardial effusion since there is no pericarditis. If there are S-T changes, then coronary insufficiency is most likely. Those EKG changes due directly to myxedema of the heart are reversible after treatment. When the EKG does not change toward normal, associated heart disease is generally present—usually coronary atherosclerosis. There are no EKG changes which are pathognomonic of myxedema.

The treatment for myxedema is thyroid replacement therapy. Desiccated thyroid extracts or triiodothyronine may be used. Desiccated thyroid is most generally prescribed at the present time. A very small dose should be given to begin with ($\frac{1}{4}$ grain). This should be gradually increased over a period of several months until all signs of the disease have disappeared. Too rapid progression may cause anginal pain, even in patients with no previous history of angina. Myocardial infarctions have been precipitated. The maintenance dose is usually around one to three grains of desiccated thyroid daily. Heart failure, arrhythmias and other heart disease must be treated by the usual methods. Patients with myxedema are extremely sensitive to morphine and other opiates, and only small doses should be used since respiratory depression and peripheral collapse may be induced.

Prepared at the request of the Committee on Professional Education of the
Georgia Heart Association.



abstracts by georgia authors

Sherman, Ida L., and Heinz Eichenwald, C.D.C., U. S. Department of Public Health, Atlanta, Ga. "Viral Hepatitis: Descriptive Epidemiology Based on Morbidity and Mortality Statistics." *Ann. Int. Med.* 44:1049-1069 (June) 1956.

Viral hepatitis comprising either one or both of two entities, infections hepatitis and serum hepatitis, has been known in the United States for the past hundred years or more, but the history of the occurrence of the disease on a nationwide scope has not previously been described. In this paper, reported case data and recorded deaths from infectious hepatitis in the United States during recent years have been used as a basis for inferences with respect to the broad epidemiological characteristics of this double entity.

There has been an increase in the number of reported cases during the period under study, reaching a peak in 1954. Maximum incidence occurred in the late winter or early spring months in the United States. The seasonal low has consistently occurred during the summer, and this feature has been observed in the Scandinavian countries and in England. Seasonal distribution of the recorded deaths, however, shows little variation during the year, suggesting that deaths may be due mainly to serum hepatitis, which is known to have an appreciable risk of death. The long-term trend of the disease, based on data from Denmark (since national case figures for the United States are available only since 1952) indicates a cyclical waxing and waning of the disease, each phase extending over a period of some five to 10 years, and emphasizing the epidemic nature of infectious hepatitis.

Such data as has been obtained on incidence by age and sex indicate that highest incidence occurs in age groups under 15 years, and that both sexes are equally susceptible to the disease. Recorded death data show increasingly higher rates with increasing age, indicating that hepatitis is more severe in older age groups or that incidence of serum hepatitis occurs more frequently. Analysis of mortality data by age and sex shows an excess of female deaths in the age groups extending from the menarche through the menopause, and an excess of male deaths in age groups over 50 years. The reasons for these differences are not apparent.

Pfeiffer, Carl C., Elizabeth H. Jenny, and William H. Marshall, 69 Butler St., S.E., Atlanta, Ga. "Experimental Seizures in Man and Animals with Acute Pyridoxine Deficiency Produced by Hydrazides." *Electroencephalog. & Clin. Neurophysiol.* 8:307-315 (May) 1956.

Three hydrazides, semicarbazide, thiosemicarbazide and thiocarbohydrazide, were given orally to schizophrenic patients to produce a temporary epileptic state for a one to five hour period. Dur-

ing this time, seizures may occur spontaneously or they may be induced by auditory or photic stimulation. The photic stimulation induced seizure or spontaneous seizure is thought to be less traumatic than electrically induced seizures. Pyridoxine will antidote completely this temporary epileptic state. Thiocarbohydrazide is the most potent hydrazide for the production of this epileptic state. An oral dose of 100 to 200 mg. of Thio-C will produce a spontaneous seizure in one to three hours. Hydrazides produce vomiting as a side action which is apparently central in origin. Electroencephalographic studies in animals and man indicate that these seizures all probably originate subcortically. It remains to be determined whether hydrazide convulsions are more effective in schizophrenia than are electrically induced convulsions.

Rollins, L. C., and D. H. Poer, Piedmont Hospital, Atlanta 3, Ga. "Mediastinal Emphysema and Bilateral Pneumothorax Following Surgery of the Neck." *Am. Surgeon* 22:567-572 (June) 1956.

Mediastinal emphysema and pneumothorax constitute a severe although uncommon complication of any surgery of the neck involving incision into the pretracheal or middle layer of the deep cervical fascia.

The surgeon may cause this complication if the pleura is inadvertently incised beneath Sibson's fascia at the cupola of the lung and the anesthesiologist may be at fault if hyperinflation of the pulmonary circuit has occurred. In many instances, however, the air enters the mediastinum and pleural space directly by way of fascial planes, as has been confirmed by autopsy findings.

The most common early findings are subcutaneous emphysema, pain in the chest, variation from the normal respiratory pattern, evidence of circulatory failure, and auscultatory findings. Roentgen examination of the chest corroborates the diagnosis and may be used to follow the progress of this complication.

Oxygen, analgesics, and the use of an airway in the unreacted patient are discussed. The instigation of immediate needle aspiration or closed thoracotomy drainage in tension pneumothorax is mandatory and positive pressure apparatus should be avoided.

Close observation is essential to lower the high mortality rate of this unusual postoperative complication.

Ragers, James V., Jr., and Albert E. Roberto, Emory Universal Hospital, Emory University, Ga. "Circumscribed Pulmonary Lesions in Periarthritis Nodosa and Wegener's Granulomatosis." *Am. J. Roentgenol.* 76:88-93 (July) 1956.

Two cases of Wegener's granulomatosis and one case of periarthritis nodosa with a round pulmonary infarct are presented. The tendency for cavitation in

necrotizing granulomata of Wegener's granulomatosis is emphasized. This with the clinical findings suggesting generalized vasculitis or glomerulitis should arouse a strong suspicion of Wegener's granulomatosis. Pulmonary infarction associated with classic periarthritis nodosa should also be considered.

Shek, Jahn L., Jerame A. Cape, and Gardan D. Myers, Battey State Hospital, Rome, Ga. "Giant Air Cyst(s) as a Sequela of Pulmonary Tuberculosis." *J. Thoracic Surg.* 32:96-102 (July) 1956.

This is a report of six cases of proven tuberculous patients in Battey State Hospital who, under antituberculous drug and other medical therapy, eventually yielded x-ray picture indistinguishable from that of cystic disease of lung, or pneumatocele. They represent the end result of continuous resolution and regression of extensive tuberculous process. They were all resected, including three pneumonectomies, and no histopathological evidence of tuberculosis is recognized in the resected specimens. The completeness of such resolution is amazing, although they are the exception rather than the rule. Question is raised about the desirability of postoperative antituberculous drug therapy in such cases. Comment is made regarding the roentgenologic similarity between these and another resected group which does have residual disease in the "cystic" (cavity) wall, not reported in this series. The pathogenesis of such giant air cyst is also briefly brought up. Attention is called to these air cyst(s) as a sequela of pulmonary tuberculosis.

Walker, Exum, Franklin C. Miles, and James R. Simpson, 490 Peachtree St., N.E., Atlanta, Ga. "Partial Trigeminal Rhizotomy Using Suboccipital Approach." *Arch. Neural. & Psychiat.* 75:514-521 (May) 1956.

Experiences from 250 cases of trigeminal neuralgia are reported in which the trigeminal root was partially sectioned at the pons using the suboccipital operative approach. The results are compared to those reported in the literature in which the root was sectioned near the ganglion using the subtemporal operation.

It was pointed out that when the root was partially sectioned at the pons the sensory loss was much less than when the root was divided near the ganglion and that often the patient would be unaware of any numbness in the face. The corneal reflex was seldom lost even when pain involves the first division. Numbness within the mouth was also less so that the function of eating was disturbed less. Motor functions were never disturbed and distressing paresthesias occurred in only two cases.

It was felt that the results using the suboccipital approach were superior to those when the subtemporal operation was used.

Irwin, C. E., Ralph W. Coonrod, Thomas Gucker III, and J. B. Wroy, 340 Boulevard, N.E., Atlanta 12, Ga. "The Importance of Plantar Muscles in Paralytic Varus Feet." *J. Bone & Joint Surg.* 38:563-566 (June) 1956.

The authors reviewed the results of stabilization of nearly flail talipes varus feet over a 10-year period at the Warm Springs Foundation. They were impressed by the frequency of the recurrence of the deformity in a satisfactorily stabilized foot. During the 10-year period, 47 nearly flail varus feet had been stabilized and 22 of these deformities had recurred. Ninety per cent of these recurrent deformities had good or better toe intrinsic muscle power. In 25 feet in which there had been no recurrence the intrinsic muscle strength was below functional value. These findings indicated to the authors that the unopposed intrinsic muscle action was the cause of the recurrence and created a need for the elimination of the deforming action of these muscles.

Various approaches were used in arriving at a satisfactory procedure to solve the problem. The deforming muscles were the short toe flexors supplied by the medial plantar nerve, the lumbricales, and interossei supplied by the deep branch of the lateral plantar nerve. The combined operative procedure which proved best in our hands to correct the deforming factor was first, plantar fasciotomy; second, myototomy or removal of a section of the short flexor mass; third, neurectomy of the deep branch of the lateral plantar nerve. This left behind the abductor hallucis supplied by the medial plantar nerve and the abductor digiti quinti supplied by a branch of the lateral plantar nerve proximal to the site of neurectomy.

These remaining muscles provided adequate and balanced toe flexion and the main deforming factors had been removed.

Rogers, James V., Jr., and Elizabeth K. Adams, Emory Hospital, Emory University, Go. "Gastric Lipoma." *Radiology* 67:84-86 (July) 1956.

A single case of gastric lipoma is presented in which there was sufficient fat content that the tumor was identifiable as a lipoma radiographically. This is the second gastric lipoma reported in the literature in which the diagnosis could be established preoperatively. A dermoid cyst is the only other mass which might give a similar appearance in the stomach. No case of gastric liposarcoma could be found in review of the literature.

Wycoff, H. D., Ph.D., Public Health Service, Augusto, Go. "A Microassay for Plasmo Fibrinogen." *J. Lab. & Clin. Med.* 47:645-648 (April) 1956.

This space presents a procedure for the determination of plasma fibrinogen which requires only 0.1 ml. of plasma for reproducible results. The fibrinogen is clotted by adding a solution of thrombin to the plasma. The clotted fibrin is collected and the amount is measured either by weighing it on a microchemical balance or by digesting it in sulfuric acid and nesslerizing the ammonia directly. The procedure is given in detail. The plasma of normal young men averaged 0.224 per cent fibrinogen by this method and that of normal adult rats was 0.222 per cent. The fibrinogen level of patients with advanced carcinoma averaged 0.450 per cent while that of rats bearing transplanted lymphosarcomas averaged 0.414 per cent.

Harris, Ad, Public Health Service, Chomblee, Ga. "TPI Test as a Daily Routine Laboratory Procedure." *Am. J. Pub. Health.* 46:723-727 (June) 1956.

TPI test results obtained on 1800 serums submitted by several hundred physicians through 50 state and territorial Department of Health laboratories show that (1) a lower percentage of positive findings was obtained from female donors (37.4 per cent) than from male donor group (48.5 per cent), (2) serums from patients with histories of past syphilitic infections produced a greater percentage of positive findings (5 per cent) than did those without such history (42.5 per cent), (3) in the Biologic-False-Positive diagnosis category, agreement with medical opinion was 60 per cent, and (4) total agreement between current diagnoses (Syphilis and BFP) and TPI test results was approximately 60 per cent. Variation of the TPI test reactivity level as reflected in control serum titers in 125 test runs is discussed.

Schubert, Joseph H., and Lillian V. Holde-mon, Public Health Service, C.D.C., Chamblee, Ga. "A Modified Precipitin Technique for Determining the Source of Mosquito Blood Meals." *J. Trop. Med.* 5:272-273. (March) 1956.

Precipitin tests on engorged mosquitoes to determine the mosquitoes host were performed rapidly and efficiently with a small size capillary tubing of 1.2-1.5 mm. O.D. These tubes were savings of reagents and were discarded after use without washing. The reaction was sufficiently specific so that mosquitoes which fed on the magpie (passerine bird) could be differentiated from those which fed on chicken (gallinaceous bird).

Voluntary Health Insurance

BENEFIT PAYMENTS under voluntary health insurance programs, designed to help people pay hospital and doctor bills, are running 20 per cent higher so far this year than in 1955, the Health Insurance Council announced, in releasing the findings of its annual survey of the extent of voluntary health coverage in the United States. In 1955 such payments amounted to 2.5 billion dollars.

The increase in benefit payments, the Council said, reflects both the progress made by the American people in bringing their health insurance protection to more nearly adequate levels, and the continued spread of ownership.

As of July 31, the Council estimates, some 110 million persons, an all-time high, were covered by hospital insurance, while 94 million had surgical protection, 58 million had policies that cover regular

medical expenses, and seven million were insured against major medical expenses.

The survey, which is made annually by the Health Insurance Council, is based upon reports of health insurance programs conducted by insurance companies, Blue Cross-Blue Shield, and other plans.

Commenting on the advances of voluntary health insurance for the year, the report stated, "The rapid growth of hospital, surgical and regular medical expense insurance during 1955 was a continuance of truly spectacular trends that have been in progress for more than a decade." During the year, the report went on to say, the number of people with hospital insurance increased by 6.1 per cent, surgical insurance was up 7.0 per cent and regular medical expense protection made a 17.5 per cent gain. Major medical expense insurance made the greatest advance with an increase of 138 per cent.



physician's bookshelf

Books Received

Ivy, A. C.; Pick, John F.; and Phillips, W. F. P., *Observations on Krebiozen in the Management of Cancer*, Henry Regnery Company, Chicago, 1956, 88 pp., \$2.50.

Wolstenholme, G. E. W., and Millar, Elaine C. P. (Editors); *Ageing in Transient Tissues*, Ciba Foundation Colloquia on Ageing, Vol. 2; Little, Brown and Company, Boston, 1956, 263 pp., 96 ill., \$6.75.

Wolstenholme, G. E. W., and O'Connor, Cecelia M. (Editors); *Internal Secretions of the Pancreas*, Ciba Foundation Colloquia on Endocrinology, Vol. 9; Little, Brown and Company, Boston, 1956, 292 pp., 100 ill., \$7.00.

Proceedings, World Congress of Anesthesiologists, September 5-10, 1955, Scheveningen, The Netherlands; Burgess Publishing Co., Minneapolis, 1956, 321 pp.

Of Water, Salt and Life; Lakeside Laboratories, Inc., Milwaukee, 1956, 72 pp., 31 plates, \$7.50.

Reviews

Stott, C. P., S.R.N., C.M.B., and M. Fischer-Williams, M.R.C.P., Ed., *THE MANAGEMENT OF ACUTE POLIOMYELITIS*, E. & S. Livingstone Ltd., Edinburgh and London, The Williams and Wilkins Company, Baltimore, 1955, 99 pp., \$3.00.

This book consists of a brief and simple description of the clinical course of poliomyelitis and a more detailed account of nursing care in this disease. Unfortunately, the title does not indicate that the volume is principally concerned with nursing management. Isolation techniques, nursing care of non-paralytic, paralytic, and respirator cases, and the use of hot packs are adequately considered. The section on physiotherapy which emphasizes those methods which can be employed by ward personnel without special training in this field deserves emphasis. The attention directed towards the use of barbiturates as sedatives and opiates as analgesics in patients with acute poliomyelitis will prove disturbing to those persons who feel that these drugs are essentially contraindicated in this situation. Although the book is designed primarily for nurses, the limitations of their responsibility in nursing patients with poliomyelitis is not clearly defined. The book is not adequate for physicians undertaking a study of the management of acute poliomyelitis. If used under adequate supervision it might be a useful adjunct in teaching students poliomyelitis nursing.

Edward W. Hook, M.D.

Bland, John H., M.D., *CLINICAL RECOGNITION AND MANAGEMENT OF DISTURBANCES OF BODY FLUIDS*, second edition, W. B. Saunders Company, Philadelphia, 1956, 552 pp., 109 figs., \$11.50.

As Dr. Bland states in his preface, a second edition of his book was made necessary by the "pyramiding mass of information," both factual and conceptual, in the field of water, electrolyte and hydrogen ion metabolism. The importance to the clinician in keeping in touch with this information cannot be overstated. Unfortunately, there is no subject more complex, or one harder to digest, in all of clinical medicine. The author does not overlook this fact, and does his utmost to simplify the basic essentials of his subject matter before considering complicated disturbances in body chemistry. Chapters 2

and 3 are the essence of the work; if these are studied carefully, the following chapters that deal with specific derangements can be readily understood. Otherwise, the practitioner, unless he has an unusual flair for chemistry, may find himself completely bogged down among the cations.

John F. Stegeman, M.D.

Conn, Howard F., M.D. (Editor), *CURRENT THERAPY 1956, LATEST APPROVED METHODS OF TREATMENT FOR THE PRACTICING PHYSICIAN*, W. B. Saunders Company, Philadelphia, 1956, 632 pp., \$11.00.

The 1956 *Current Therapy* is the eighth edition of an annual series presented to the practicing physician. As in the past it is written by specialists in the various fields of medicine. The editorial board and the authors of the individual subjects are all outstanding men in the field of medicine.

The division of the book into the various systems, as well as the indexing saves a great deal of time.

One very definite criticism of the reviewer is the placing of the problem of phlebothrombosis and thrombophlebitis under obstetrics and gynecology. Certainly they belong in the field of cardiovascular disease, and the busy physician would get very little from that presentation in the book.

Another criticism is that certainly there should be more definite presentation, perhaps by a heart surgeon, of the procedures available in both acquired and congenital heart disease.

The 1956 *Current Therapy* is a valuable book for every busy practicing physician, for quick reference. It is invaluable to the man in the smaller community who does not have frequent scientific meetings available and an up-to-date medical library. Within its limitations, we would recommend the 1956 *Current Therapy* for every busy physician's desk.

George R. Dillinger, M.D.

Ellis, Rhoda, Ph.D., *DICTIONARY OF DIETETICS*, Philosophical Library, New York, 1956, 152 pp., \$6.00.

This book lists numerous terms and definitions related to the field of dietotherapy, nutrition, food composition, food cookery, as well as short descriptions of some of the more common pathological conditions.

The content material covers, in some degree, a wide number of fields; for example, the author included the word "thiouracil" and defined it as "a substance derived from thiourea used in medicine to treat toxic goitre." The author has endeavored to cover many fields, including pharmacology and therefore the title "DICTIONARY OF DIETETICS" is somewhat misleading and the content material does not fully cover the chosen field of dietetics.

The material presented in this book is such that an intelligent lay person may find it interesting and informative to consult. Student nurses and dietetics students, may find it satisfactory as a reference source. The information contained herein might also be useful in a physician's personal library or a hospital library.

Mrs. L. P. Ziska, Head Dietitian
St. Joseph's Infirmary
Atlanta, Ga.

THE ASSOCIATION

Committee on Legislation

THE FIRST MEETING of the 1956-57 Committee on Legislation was held at 1 p.m., Sunday, August 5, 1956, at the Academy of Medicine, Atlanta. Following a luncheon, the meeting was called to order at 1:40 p.m. by M. F. Simmons, Decatur, Chairman.

Members present included Chairman Simmons; Vice-Chairman Eustace A. Allen, Atlanta, and J. Frank Walker, Atlanta. Also present was Mr. John F. Kiser, MAG Headquarters Office.

The first item of business was a discussion of general committee activity by Dr. Simmons. He read from the Constitution and By-Laws the duties of the committee and discussed the activities of the previous committee.

Mr. Kiser read reports for the past 10 years and provided other background material.

The next item of business was the proposed amendment to the Medical Practice Act as recommended by the Liaison Committee to Study Revision of the Medical Practice Act and also by the Executive Committee of Council.

The committee voted approval of this measure and asked that the Headquarters Office refer the bill to the AMA Law Department and also to the Attorney General's office for their suggestions.

The next item of business consisted of the resolution approved by the House of Delegates in regard to the hiring of handicapped persons. Dr. Simmons reported on a recent meeting of a joint committee to discuss this matter. The committee consisting of representatives of the Associated Industries of Georgia, the Chamber of Commerce, Cotton Manufacturers Association of Georgia, the Georgia Heart Association, and the Medical Association of Georgia will handle the work of this proposed bill. The committee voted its support of the joint committee and agreed to work with the committee in every way possible.

The next item of business was the Resolution on Sterilization approved by the House of Delegates and referred to the Legislation Committee for action. It was voted to ask approval of this bill of the following organizations: the Georgia State Ob & Gyn Society, the Georgia Urological Society, and the American Medical Association.

The committee voted to ask Mr. Dunaway, Association Counsel, to draw up a bill in conformity with the resolution on marriage law revision. This is to be presented at the next meeting of the committee.

Mr. Kiser presented general information about the handling of legislative work in the Headquarters Office. He pointed out that a number of M.D.'s were running for the Georgia Legislature, and it was voted to invite those elected after the September 12 primary to serve as advisors to the Committee on Legislation.

The committee asked Mr. Kiser to draw up a district plan for arranging dinners for legislators in each of the 10 congressional districts and suggest key men to be appointed in the different districts, the dates of the various meetings, the cost of the meetings, and the possibility of the availability of assistance of the Woman's Auxiliary.

The next item of business was the discussion of na-

tional legislation by Eustace Allen, Atlanta, vice-chairman of the committee in charge of national legislation.

It was voted to hold a dinner after the national election in November and to invite Tom Alphin of the AMA Washington Office to discuss national legislation with various key men from around the state.

The possibility of a luncheon or dinner meeting with former Governor Herman Talmadge was also discussed. Dr. Allen was instructed to work out the details of this meeting.

It was tentatively decided that the committee would meet again in September and in November.

There being no further business, the meeting was adjourned.

Council of the MAG

THE FALL MEETING of the Council of the Medical Association of Georgia was called to order at 4:30 p. m., September 15, at the King and Prince Hotel, St. Simons Island, by vice-chairman George R. Dillinger, Thomasville, in the absence of the chairman.

Present during the meeting were the following officers: Hal M. Davison, Atlanta, President; David Henry Poer, Atlanta, Secretary-Treasurer; Thomas W. Goodwin, Augusta, Speaker of the House of Delegates. The following councilors were present: Lee Howard, Sr., Savannah, 1st District; George R. Dillinger, Thomasville, 2nd District; W. G. Elliott, Cuthbert, 3rd District; J. W. Chambers, LaGrange, 4th District; Henry H. Tift, Macon, 6th District; Ralph W. Fowler, Marietta, 7th District; Vice-Councilor, acting in the absence of the councilor; F. G. Eldridge, Valdosta, 8th District; Charles Andrews, Canton, 9th District. Vice-Councilors present included Clarence B. Palmer, Covington; James M. Hicks, Brunswick, and Luther Wolff, Columbus. Also present were Chris J. McLoughlin, Atlanta, Chairman Public Service Committee; Edgar Woody, Jr., Editor, JMAC; Albert M. Deal, Chairman, State Board of Medical Examiners; Walter Brown, Savannah, President-elect of the Georgia Medical Society; Joe Mercer and C. S. Britt, Brunswick, representatives, Glynn County Medical Society, and the Messrs. Milton D. Krueger and John F. Kiser of the MAG Headquarters Office.

The invocation was presented by Dr. Hicks.

The chairman then called on Mr. Krueger to read the minutes of the Council meeting of June 2-3, 1956, and minutes of the Executive Committee meetings of July 1 and August 5.

In the August 5 minutes, this correction was noted by Dr. Chambers: Roy Gibson, Columbus, was substituted for Dr. Holder, LaGrange, on the Workmen's Compensation Committee.

It was voted to increase the expenditure for the Regional Medical Care meeting of August 19 from 50.00 to \$100.00.

Dr. Chambers then assumed the duties of chairman and presided during the rest of the meeting.

Public Service Committee Report—This first item of business was presented by the chairman, Chris McLoughlin, Atlanta, who gave five items for consideration by Council: (1) a report on the Public Relations Institute held by AMA; (2) the need for an indoctrination booklet to be published by the Association and distributed to new Members; (3) a request from the Medical Assistants Association of Georgia for approval of its organization and constitution and by-laws; (4) ap-

proval of a Public Service Committee recommendation that automobile safety stickers be furnished each member of the Association; (5) that the Association consider cooperating with the oil companies in a campaign for improvement of service station rest rooms.

It was voted to appoint a reference committee, composed of Charles Andrews, Canton, chairman; George R. Dillinger, homasville; and F. G. Eldridge, Valdosta, to study the recommendations of Dr. McLoughlin's committee and report to the Sunday morning session of Council.

Tax Status of the Association—Hal M. Davison, President, and Chairman of the Legal Counsel Committee, presented a report on the tax status of the Association. It was voted to make no change in the present tax status of the Association.

Legal Counsel Committee Report—Dr. Davison, Chairman of the Legal Counsel Committee, discussed the House of Delegates' resolution requesting that Council select the most competent legal advice in regard to the various aspects of the practice of medicine in Georgia. Dr. Davison reported on two meetings of the committee and presented a recommendation of the Executive Committee of Council that the legal firm of Alston, Sibley, Miller, Spann and Shackelford be selected. Mr. Krueger read the conclusions of the "Shackelford Report" and a letter from Mr. Shackelford dated uJly 12, 1956.

Following further discussion it was voted to employ this firm to study and advise the profession per the 1956 House of Delegates directive; the fee for this service to be between \$2,000 to \$3,000.

Medical Education Committee—This report was presented by Thomas W. Goodwin in the absence of the committee chairman, R. C. McGahee, Augusta.

Following the report there was discussion, and Dr. Poer presented the report of the Emory Subcommittee of which Charles Stone of Atlanta is Chairman.

Mr. Krueger reported that the new AMA policy in regard to private practice of medicine by medical schools was sent to the deans of the medical schools and to the Board of Regents.

There followed a long discussion in regard to the implications of the new AMA policy on the local level. Dr. Goodwin presented some problems of the Richmond County Medical Society, and there followed further discussion by Drs. Poer, Goodwin, Wolff, ift, Davison, Eldridge, and Chambers.

Meeting of Committee Chairmen—Dr. Davison discussed the possibility of holding a meeting with the Association committee chairmen to encourage their work. It was voted to sponsor a dinner-meeting of the committee chairmen in the near future.

Institution-Physician Relation Committee Report—The report of the Institution-Physician Relations Committee was presented by the Chairman Henry H. ift, Macon.

It was voted that this report, when it is completed by the Headquarters Office, be made available to committees and legal counsel within the Association that may be concerned with it.

There being no further business, the meeting was recessed until Sunday morning.

Reconvened Meeting of Council September 16, 1956
CHAIRMAN CHAMBERS called the meeting of Council to order at 9 a. m. September 16.

In addition to the councilors present Saturday afternoon, September 15, 1956, was J. G. McDaniel, Atlanta. Also present was Mr. Sam M. Butler, Executive Director of the Blue Cross-Blue Shield Physicians Service, Inc., of Columbus, Georgia.

Public Service Reference Committee Report—Dr. Charles R. Andrews, chairman of a Council appointed Reference Committee, which included Drs. Dillinger and Eldridge, reported on the four points previously submitted to the Council by Public Service Committee Chairman Chris McLoughlin, as follows:

(1) Automobile safety stickers for the active dues paying membership approved, if funds for the project were available; (2) Membership indoctrination brochures were approved, if funds were available, and it was further recommended that these brochures be sent not only to be members, but also be sent to the present active members of the Association; (3) The endorsement of the "Medical Assistants Association" by the MAG was approved, if this organization includes in their constitution and by-laws the formation and close liaison of an advisory group from the Medical Association of Georgia whose duties would be to actively aid and advise the Medical Assistants Group; and (4) That the problem of service station sanitation of rest rooms be referred back to the Public Service Committee for further study and subsequent report to Council. On motion duly made and seconded, the report of the reference committee was approved.

Legislative Committee Report—Assistant Executive Secretary Mr. John F. Kiser, reported for M. Freeman Simmons, Decatur, Chairman of the Association's Legislation Committee.

Specific legislation envisioned by the Legislation Committee includes problems concerned with (1) handicapped employees under workmen's compensation laws; (2) sterilization laws; (3) marriage health laws; (4) and, amendments to the medical practice act.

At this time, Mr. Kiser introduced Albert Deal, Statesboro, Chairman of the State Board of Medical Examiners. Dr. Deal read a critical statement concerning cooperation between the Medical Association of Georgia and the State Board of Medical Examiners and made certain suggestions about changes to be introduced as amendments to the Medical Practice Act. Discussion of these changes ensued, and Dr. Deal asked that institutional licensing provisions be approved in principle.

It was moved that this institutional licensing provision be approved in principle for inclusion in the Medical Practice Act Amendments. Dr. Deal pointed out further suggestions and changes in the Medical Practice Act revision which were approved in principle and so referred to the Legislation Committee, of which Dr. Deal is a member.

Annual Session Committee Report—J. G. McDaniel, Atlanta, Chairman of the Council Annual Session Committee, reported that a meeting had been held with the officers of Georgia Medical Society concerning the arrangements for the 1957 MAG Annual Session. He also reported that on August 17, 1956, a meeting was held with the elected specialty society program chairmen to arrange the scientific program. Dr. McDaniel read the program as arranged at this meeting.

By general agreement the program, as presented above, was approved by Council, and it was further noted that the Council Annual Session Committee com-

mended Walter Brown, President-elect of the Georgia Medical Society, for his cooperation and contribution to this program.

Professional Relations Problem—F. G. Eldridge, Valdosta, presented to Council a professional relations problem that he was concerned with as Councilor of the Eighth District. Further data was supplied by Mr. Kiser, Dr. Mercer, and Dr. Poer; and it was recommended and by general agreement approved, that Dr. Eldridge, as Councilor of the Eighth District, personally intercede in this problem in an attempt to act as "peace-maker" for the profession.

"Medicare Public Law 569—Secretary David Henry Poer gave a detailed history of Public Law 569, an explanation of the law, and what the law means to Georgia physicians. He further reported on the AMA meeting on Public Law 569, Chicago, July 28-29, and the Atlanta Southeastern Regional Conference meeting on Public Law 569, August 18-19, 1956.

Dr. Chambers then informed the Council members that as Chairman of Council, he had appointed a committee to study and recommend *usual* fees for the medical and surgical procedures requested by the Department of Defense. Dr. Chambers explained that appointees to this Special Committee on Public Law 569 Fee Schedule were selected with reference to the area of Georgia they represented and their specialty. Dr. Chambers then presented the report of this Special Committee on Public Law 569 Fee Schedule to the members of Council (this report consisted of allocating relative value units representing a given dollar value to the 200 most frequent procedures as requested by the Department of Defense.

It was moved that the Medical Association of Georgia cooperate with the Department of Defense in implementing Public Law 569.

It was moved that the Council Committee on Public Law 569 Fee Schedule report be accepted as a basis for further Georgia deliberation by designated MAG physician agent or agents. This motion was approved.

It was moved that the Council Committee on Public Law 569 Fee Schedule continue to function correlating material received from the previous mentioned sources and further that this committee so report back to Council for approval of the Public Law 569 Fee Schedule.

Further discussion on both the fee schedule and selection of the fiscal agent ensued.

It was moved that the Executive Committee of Council be requested to investigate costs and office procedures inherent in this Public Law 569 program for Georgia and so report back to the Council for action. This motion was approved with one dissenting vote.

Headquarters Office Report—A communication from Mr. John A. Dunaway, President of the Industrial Health Council of Greater Atlanta, Inc., addressed to Dr. Davison, MAG President, requesting that the Medical Association of Georgia place its stamp of approval upon the Industrial Health Council of Greater Atlanta, Inc. This matter was referred to the Association's Industrial Health Committee with the request that it make a recommendation on this matter to the Council at its next meeting.

A communication from Lester M. Petrie, Director Preventable Disease Services, State Department of Public Health, addressed to MAG President Davison was read concerning the recently enacted "Compulsory Pre-

employment Physical Examination Laws" for all new employees of the State of Georgia, effective July 1, 1956. This matter was referred to Thomas Sappington, Thomaston with the request that Dr. Sappington make a recommendation to Council on the matter.

A communication from the State Medical Society of Wisconsin in reference to endorsement of their candidate for the President-elect of the AMA was read, and it was requested that this matter be referred to the AMA-MAG Delegates of the Association with no instruction therein, leaving this matter to the discretion of the delegates.

Chairman Chambers then called for unfinished business and there being none, the chairman called for new business. President Davison brought up a federal civil defense problem as presented to Dr. Davison by the Health Service Implementation Committee of the Federal Civil Defense Administration, Region III, meeting in Columbus, Georgia, on August 14, 1956. The resolution requested endorsement of the Association pertinent to a problem of liaison with the Civil Defense Administrator of the United States. This resolution was approved by general agreement.

A communication from Needham B. Bateman, Atlanta, concerning more cooperation between the medical profession and clergymen was discussed and this matter was referred to the Public Relations Committee for direct action.

Dr. Elliott introduced a request from the Georgia Academy of General Practice that they be allotted space in the *Journal of the Medical Association of Georgia* for material and data that the Academy wishes to present to all the physicians of Georgia. By general agreement, this request was referred to the Publications Committee.

By unanimous motion, a rising vote of thanks was given to Dr. and Mrs. James M. Hicks, Brunswick, for their hospitality and aid in arrangements on the occasion of this Brunswick Council meeting.

There being no further business, the meeting was adjourned at 12:55 p. m.

Executive Committee of Council

THE EXECUTIVE COMMITTEE of Council was called to order by Chairman Chambers at 1:00 p. m., Sunday, September 16, in the King and Prince Hotel, St. Simons Island, Georgia.

Members of the Executive Committee present were: Hal M. Davison, Atlanta; David Henry Poer, Atlanta; J. W. Chambers, LaGrange; and George R. Dillinger, Thomasville.

Rural Health Committee Appointment—J. L. Walker, Clarkesville, was appointed Chairman of the MAG Rural Health Committee, and the Executive Secretary was requested to advise Dr. Walker of a vacancy on his committee, and ask Dr. Walker to inform Executive Committee of Council according to his discretion on the filling of this vacancy.

"Medicare" Public Law 569—By general agreement, it was the recommendation of the Executive Committee that Drs. Poer and Dillinger and Attorney Shackelford make arrangements to secure in Washington, D. C., pertinent information requested by Council at their September 15-16 meeting on the Public Law 569 program.

There being no further business, the meeting was adjourned at 1:25 p. m.

INFORMATION

ANNOUNCEMENTS

The American College of Obstetricians and Gynecologists—Fifth Annual Clinical Meeting, The Palmer House, Chicago, Ill., November 7-9, 1956. Highlights of the meeting will be round-table discussions and breakfast conferences; panels on "Anesthesia in Obstetrics," "Adoption," and one on "The Pathology of the Breast" will be held. Formal papers on "Prediabetic State," "Use of Hypotensive Drugs in Obstetrical Toxemia," etc. will be presented. "Consultation Hours" will be held four times during the meeting for questions to be answered. For information, contact Patricia Dorr, Public Relations, American College of Obstetricians and Gynecologists, 116 South Michigan Ave., Chicago 3, Ill.

The American College of Physicians is presenting eight postgraduate courses in the fall and winter of 1956-57. Four have been given, and the remaining four are as follows: *Selected Problems in Internal Medicine*, November 26-30, 1956, University of Oklahoma School of Medicine, Oklahoma City, Okla. Director: Stewart G. Wolf, M.D. Fee: members, \$30.00, non-members, \$60.00. *Gastro-Enterology*, December 3-7, 1956, University of Pennsylvania Graduate School of Medicine, Philadelphia. Director: Henry L. Bockus, M.D. Fee: members, \$30.00, non-members, \$60.00. *Pathologic Physiology of the Blood Dyscrasias*, February 18-22, 1957, Washington University School of Medicine, St. Louis, Mo. Directors: Carl V. Moore, M.D., William J. Harrington, M.D., and Edward H. Reinhard, M.D. Fee: members, \$30.00, non-members, \$60.00. *Basic Concepts of Clinical Electrocardiography*, December 3-8, 1956, University of Utah College of Medicine and Salt Lake General Hospital, Salt Lake City, Utah. Director: Hans H. Hecht, M.D. Fee: members, \$30.00, non-members, \$60.00.

Southern Branch, American Public Health Association Meeting, May 29-31, 1957, Asheville, N. C. Delegates are urged to write early for reservations. Address applications to William D. Turner, Jr., George Vanderbilt Hotel, Asheville, N. C. Negro applications should be sent to Mrs. H. K. Harrison, 23 Eloise St., Asheville.

Post Graduate Course in Pediatric Allergy—New York Medical College Flower and Fifth Avenue Hospitals, November 7, 1956 - May 29, 1957 (30 sessions)—Wednesdays, 9 a.m. to 4 p.m. Fee—\$300. Research fellowships in pediatrics available. Apply: Office of the Dean, New York Medical College, Fifth Ave. at 106th St., New York 29, N. Y.

84th Annual Meeting American Public Health Association—Atlantic City, N. J., November 12-16, 1956. For information, write to the American Public Health Assn., 1790 Broadway, New York, N. Y.

Fiske Essay on Infertility — The Caleb Fiske Prize of the Rhode Island Medical Society will be given this year for the best dissertation on "The Present Day Treatment for Infertility." The paper should be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of \$350 is offered. Essays must be submitted by January 1, 1957. For complete information, write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis St., Providence 3, R. I.

American College of Physicians Postgraduate Courses—The following courses will be offered in the fall of 1956: Recent Advances in Cardiovascular Disease, Clinical Neurology, Internal Medicine, Recent Advances in Internal Medicine, Selected Problems in Internal Medicine, Gastroenterology, Electrocardiography, Pathologic Physiology of the Blood Dyscrasias. For information as to dates and location of each course, write to The American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa.

Southeastern States Cancer Seminar — George Washington Hotel, Jacksonville, Fla., November 7 and 8, 1956. Meeting sponsored by Duval County Medical Society, under the auspices of the Florida Division of the American Cancer Society, Florida State Board of Health, and the Graduate School of Medicine of the University of Florida. No registration fee; room reservations may be made direct with the hotel. For information contact Dr. Harry W. Reinstine, Jr., Publicity Chairman, Cancer Committee, P. O. Box 4545, Jacksonville 1, Fla.

Interim Meeting of the Georgia State Obstetrical and Gynecological Society.—Ralston Hotel, Columbus, Ga., November 16, 1956. This meeting is held in conjunction with the Alabama State Obstetrical and Gynecological Society and will open at 9:00 a.m. Guest speakers include Dr. Frank Whitacre, Vanderbilt University School of Medicine, and Dr. Jason Collins, Tulane University School of Medicine.

Urology Award — The American Urological Association offers annual award of \$1000 for essays on the result of clinical or laboratory research in urology. Competition limited to urologists who have been graduated not more than 10 years, and to hospital internes and residents doing research work in urology. For full particulars, write the Executive Secretary, William P. Didusch, 1120 North Charles St., Baltimore, Md. Essays must be in his hands before December 1, 1956.

Van Meter Prize Award — The American Goiter Association offers the award of \$300.00 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The essays should cover either clinical or research investigations, should not exceed 3,000 words, and must be presented in English. Duplicate typewritten copies, double spaced, should be sent to the Secretary, Dr. John C. McClintock, 149½ Washington Ave., Albany 10, N. Y., not later than January 15, 1957. For further information, write to Dr. McClintock.

1957 Prize Essay Contest — The Council on Undergraduate Medical Education of the American College of Chest Physicians offers three cash awards (\$500, \$300, and \$200) to be given for the best contributions prepared by undergraduate medical students on any phase in the diagnosis and treatment of chest diseases (heart and/or lungs). For information and application form, write to the Executive Director, American College of Chest Physicians, 112 East Chestnut St., Chicago 11, Ill.

Five short-term courses related to the heart and circulatory system will be offered by the *New York University Post-Graduate Medical School* during the month of November 1956. They are as follows: *Cardiac Roentgenology* (5414), Nov. 1 and 2.

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Deals primarily with examination of the heart by fluoroscopic methods. Preceded by another full-time course, *Auscultation of the Heart*, given October 29 through 31. Both courses under the direction of J. Scott Butterworth, M.D. (2) *Electrocardiography* (5412) full-time course given from Nov. 12 through 16 dealing with modern electrocardiography and stressing the basic electrophysiology of the heart. Director: Dr. Butterworth. (3) *Peripheral Vascular Diseases* (5412) full-time course given Nov. 26 through 30, consisting of differential diagnosis; the presentation and interpretation of diagnostic methods including the oscillometer, nerve block, reflex dilatation tests, surface temperature studies, etc. Case studies stressed throughout the course. Director: A. Wilber Duryee, M.D. Other short-term courses offered in November will be *Endural Surgery*, *Pediatric Endocrinology*, *Trauma (for Surgeons)*, *Culdoscopy*, *Problems in Clinical Medicine*, *Arthritis and Allied Rheumatic Diseases*, *Hematology*, and *Diabetes and Allergy*. Further information may be obtained from the Dean, Post-Graduate Medical School, 550 First Avenue, New York 16, N. Y.

DEATHS

ISAAC BELL HOWARD, Williamson, died at his home on August 10, 1956. He was 81 years of age at the time of his death.

Dr. Howard was born in Dawson County and graduated from the Atlanta Medical College, now Emory University School of Medicine. He arrived in Williamson on June 8, 1909, and had practiced medicine there since that time.

Dr. Howard was a member of the Providence Baptist Church at Williamson and a Mason. He served for more than 20 years as a school board member for Williamson district on the Pike County Board of Education.

In 1949 the people of the county honored Dr. Howard with a special day in honor of his having practiced medicine in Williamson for 40 years. At that time he had delivered 2,643 babies and had worn out 26 automobiles.

Funeral services were held at the Providence Baptist Church with burial in the church cemetery. Survivors include three daughters: Mrs. A. N. Towson, Mrs. G. H. Barrett, and Mrs. B. K. Whitehurst.

T. W. STEWART, Lithonia, died on August 13, 1956. He was 69 at the time of his death. Dr. Stewart had practiced medicine for more than 40 years in Lithonia.

Dr. Stewart was a member of the DeKalb County Medical Society, a Mason, and was active in civic affairs.

Survivors include his wife; a son, Thomas W. Stewart, Jr., M.D., with the U. S. Army in Germany; and two grandchildren.

SOCIETIES

The members of the GLYNN COUNTY MEDICAL SOCIETY entertained their wives at a dinner at the Frederica Yacht Club recently. Social hour preceded the dinner; 44 members and their wives were present. Special guests of the evening were Dr. and Mrs. Woodrow Payne, formerly of Memphis, who have recently moved to Brunswick.

At the July meeting of the WARE COUNTY MEDICAL SOCIETY the speaker was W. C. Calhoun, Waycross surgeon. Floyd E. Davis presided over the business session; Arthur M. Knight, Jr., is secretary-treasurer, and Neal F. Yeomans is program chairman.

PERSONALS

First District

Benjamin C. Willis, Savannah, announces the association with him in the practice of neurology and psychiatry of Henry A. Brandt, former head of the department of neurology and psychiatry at the Veterans Hospital in Augusta. Dr. Brandt obtained his B.S. degree from the College of Charleston (S. C.) and did post-graduate work at the University of South Carolina. He received his M.D. degree from the Medical College of South Carolina in 1948 and interned at the Jefferson-Hillman Hospital in Birmingham. He obtained his M.S. degree in neurology from the University of Minnesota in 1952. Since then he has served with the U. S. Air Force and the V. A. Dr. Brandt is a diplomate of the American Board of Psychiatry and Neurology and a member of the A.M.A., American Psychiatry Association, American Academy of Neurology, and the Southern Medical Association.

At the recent meeting in Savannah of the Georgia Vocational Rehabilitation Staff JULIAN K. QUATTLEBAUM, Savannah, presided at a ses-

sion dealing with heart disabilities. Participants and their topics were JEFF RICHARDSON, Atlanta, "Types of Heart Diseases"; E. R. COOK, III, Savannah, "Hypertension and Its Treatment"; WILLIAM A. HOPKINS, Atlanta, "New Techniques in Heart Surgery"; and J. C. METTS, Savannah, "Psychological Aspects of Heart Disease."

GABRIEL D'AMATO, Savannah, was the featured speaker at a recent meeting of the Savannah Lions Club; he spoke on "The Meaning and Use of Psychotherapy." A former psychiatrist at Hunter A. F. B., Dr. d'Amato became a member of the staff of the Chatham-Savannah Mental Health Clinic over a year ago. He is a native of New York and a graduate of Seton Hall; he received his medical degree from Columbia University in 1947.

Joseph A. Heffernan, Jr., Savannah, announces the opening of his office at 14 West Jones Street for the practice of general medicine. A native of Savannah, Dr. Heffernan attended Marist and Cathedral Schools and graduated from Benedictine Military School before he entered the Navy. He attended the University of Georgia and the Medical College of Georgia. He interned at Mercy Hospital in Buffalo, N. Y. He is married to the former Miss Jean Stalvey of Savannah, and they have three children.

JEFF J. HOLLOMAN, Savannah, spoke at a recent meeting of the Port City Lions Club; his topic was "The Heart—Number One Killer in Chatham County."

Andro Phillips, Savannah, has announced the opening of an office for the private practice of general medicine in Savannah. His offices are located at 323 East Jones Street. Dr. Phillips has been resident physician at St. Joseph's Hospital since 1950. He is a graduate of the National University of Athens (Greece) and took post-graduate work at the University of Paris Hospital. Dr. Phillips practiced in Europe until his emigration to this country in 1950. Mrs. Phillips is the daughter of the late Kotso Kota, former prime minister of Albania who died in 1947.

Second District

No news received.

Third District

Featured in a recent column in the

(Personals)

Columbus Enquirer was Mary Tiller, of Columbus, who is director of maternal and child health for Muscogee County and is assistant health officer for Harris County. Dr. Tiller is a native of Fort Gaines and a graduate of Vanderbilt University, in public health nursing. She served with the U.S.P.H.S. and for two years as an Army nurse at Fort Bragg, N. C., during the war. She was graduated from Tulane University Medical School in 1951. She is married to RALPH E. TILLER, a Columbus pediatrician.

PETER C. GRAFFAGNINO, Columbus, is chairman of the Georgia Section for the American College of Obstetricians and Gynecologists' Chicago Meeting, November 7-9, 1956.

Fourth District

E. D. Haak, Warm Springs, addressed the Columbus Sertoma Club at a recent meeting in Columbus. His topic was Salk Polio Vaccine, and he said that the development of the vaccine was only the beginning in the fight to control the crippling effect of poliomyelitis. He also said that it already has been shown that the vaccine has been 76 per cent effective in reducing the polio throughout the nation, and that additional studies are continuing to be made.

J. WELDON KELLEY, Griffin, announces the re-opening of his office at 415 South Eighth Street in Griffin. He has recently completed a tour of duty with the Navy Medical Corps; Dr. Kelley's office was located in the Park Building in Griffin from 1952-54. He and Mrs. Kelley and their children reside at 541 South Sixth Street.

ARTHUR M. KNIGHT, JR., Waycross, who is director of the clinics of the Georgia Heart Association, recently went on an inspection tour of the clinics around the state. Participating in a recent conference with Dr. Knight were the following: GORDON BARROW, Atlanta; THOMAS ROSS, Macon; ELLISON R. COOK, III, Savannah; SIMONE BROCATO, Columbus; LESTER PETRIE, Atlanta; and ROBERT FRANK, Atlanta.

CLARENCE B. PALMER, Covington, a lieutenant colonel in the U. S. Army Reserve, is chief surgeon of the 81st Wildcat Division. Dr. Palmer spent two weeks in training

with the division at Fort Jackson, S. C., last summer.

JAMES M. SKINNER, Griffin, announces the opening of his office at 124½ West Poplar Street in Griffin. His practice is limited to obstetrics and gynecology.

James Watkins, Jr., Griffin, announces the opening of his office at 108½ North Hill Street for the practice of general surgery. He is a graduate of the University of Georgia and the Medical College of Georgia. He interned at the Baroness Erlanger Hospital in Chattanooga and practiced in Gadsden, Ala., and Jackson, Ga., until entering the Air Force. He completed his surgical training at Baroness Erlanger Hospital after his discharge from the Air Force.

Fifth District

ROBERT B. ANSLEY, Decatur, announces the association with him in the practice of medicine of Bruce S. Webster. Their offices are located at 121 Clairmont Avenue. A native of Winter Park, Fla., Dr. Webster received his medical degree from Vanderbilt University in 1954, and for the last two years has been in training at Grady Memorial Hospital, Atlanta.

THOMAS P. GOODWYN, Atlanta, state medical consultant to the Georgia Vocational Rehabilitation program, presided at one of the sessions of the recent staff training conferences held in Savannah.

CHENEY C. SIGMAN, JR., Atlanta, has temporarily interrupted his practice of pediatrics in Atlanta and Forest Park to complete a year's clinical fellowship in pediatrics at Tulane University School of Medicine, New Orleans. He plans to resume practice in Atlanta and Forest Park on June 1, 1957.

R. C. WILLIAMS, Atlanta, Director of the Division of Hospital Services, Georgia Department of Public Health, presented the keys to the New Hamilton Memorial Hospital in Dalton at the dedication ceremonies to Mr. Paul B. Fite, chairman of the hospital board. The air-conditioned hospital, with 72 beds, is located on the northern city limits of Dalton on Highway 41.

Sixth District

H. Lumpkin Coffee, formerly of Milledgeville, has opened his office in Forsyth for the practice of medicine.

He is keeping the Alexander Clinic in operation while GEORGE H. ALEXANDER, Forsyth, is convalescing from a recent illness. Dr. Coffee is a native of Forsyth and a graduate of the University of Georgia. He received his M.D. degree from the Medical College of Georgia in 1954. He has been interning at the Milledgeville State Hospital. Dr. and Mrs. Coffee, the former Miss Dana Skelton of West Point, are making their home in Jackson Heights.

LOVICK E. DICKEY, JR., Macon, announces the removal of his office to 829 First Street in Macon. Dr. Dickey limits his practice to orthopedic surgery.

CLAUDE PENNINGTON, Macon, has announced the opening of his office at 1161 Nottingham Drive, Macon, for the practice of rhinology. Dr. Pennington is a graduate of the Medical College of Georgia and has served as a medical officer with the U. S. Air Force. He was resident in ear, nose and throat medicine and surgery at Presbyterian Hospital of Columbia Medical Center in New York and took special training at Dr. Lempert's Institute in New York. Dr. and Mrs. Pennington, the former Miss Betty Weaver of Barnesville, and Dr. Pennington's mother, Mrs. Charles Soule, spent the summer in Europe with Dr. Pennington's brother. Dr. and Mrs. Pennington live at 1080 Nottingham Drive in Macon.

Seventh District

B. D. BURLEIGH, Marietta, and his 14-year-old son, Dan, left Marietta by boat, a 12 foot seven inch "drifter," on July 15th and journeyed down the Chattahoochee River to Apalachicola. The 10-day trip included gentle cruising, fighting flood waters, camping out, and even shooting a dam. Mrs. Burleigh met them at Apalachicola with the family car and boat trailer, and the family enjoyed a few days deep sea fishing before returning to Marietta.

J. A. REDFEARN, JR., Dalton, has opened an office for the practice of general medicine at 220 Pentz Street, Dalton. A native of Albany, and the son of J. A. REDFEARN, Dr. Redfearn received his medical degree from the Medical College of Georgia. For the past two years, he has been in training at Grady Memorial Hospital, Atlanta. Dr. and Mrs. Redfearn, Jr., live in the Kenner Apartments.

DON SCHMIDT, Cedartown, addressed a meeting of the Cedartown Life Underwriters Association recently. His topic was "The Medical Part of Underwriting."

JOHN L. SHEK, Rome, chief of surgery at Battey State Hospital for the last four years, has resigned, effective October 1, to go into private practice in Saginaw, Mich. He will be on the staffs of several hospitals in Saginaw and will be chest surgery consultant at the Saginaw Veterans' Administration Hospital, Saginaw County TB Hospital, and the Central Michigan TB Sanitarium.

Eighth District

Woodrow Payne, formerly of Memphis, Tenn., announces the opening of an office in Brunswick for the practice of urology. His office will be located in the Masonic Building. Dr. Payne is a native of Memphis and has been practicing there for the past three years. He is a graduate of the University of Tennessee and the University of Tennessee Medical School. Dr. Payne is married and the father of three children. He and his family reside in Good-year Park.

PAUL H. WILSON, formerly of Alma, announces the opening on August 6th of his office in Baxley for the practice of medicine. A native of Waycross, Dr. Wilson practiced medicine and surgery at Thomson for four years and has been located in

Alma since January of this year. A graduate of the Medical College of Georgia, Dr. Wilson interned at Spartanburg (S. C.) General Hospital. He is married to the former Miss Pearl McRae of Waycross and they have four children. Dr. Wilson's office is located in the Economy Drug Store Building.

Ninth District

STEWART D. BROWN, JR., Royston, has announced that the building now under construction on property adjacent to his offices in the old Brown Hospital in Royston will be a new and modern clinic built as a memorial to his father, the late STEWART DIXON BROWN, who died in 1952. The building will include seven examining rooms, two offices, lounge, emergency room, waiting rooms, x-ray room, laboratory, etc. A bronze plaque in memory of Dr. Brown's father will be placed at the entrance to the clinic.

The newly formed White County Chamber of Commerce has elected L. G. NEAL, JR., Cleveland, president.

Tenth District

Dillard L. Nix, Athens, announces the opening of his office at 1010 Prince Avenue, Athens, in association with A. P. KELLER and J. C. HOWARD. Dr. Nix is an eye, ear, nose, and throat specialist. A native of Commerce, Dr. Nix attended the University of Georgia and the Medical College of Georgia. He interned at Georgia Baptist Hospital, Atlanta,

and completed a three year residency in eye, ear, nose, and throat diseases and surgery at the VA Hospital in Atlanta. Dr. Nix is a Mason and Shriner and a member of the Baptist Church; he is also a member of the Military Surgeons Association.

EDGAR R. PUND, Augusta, was appointed by Governor Marvin E. Griffin to serve on the governor's committee for a work conference on nuclear energy held by the Southern Regional Education Board, August 1-4, 1956. The Section on Medicine and Public Health was also part of a presentation at the Southern Governors Conference.

J. RIGHTON ROBERTSON, Augusta, announces the opening of his office for the practice of urology in the Medical Arts Building, 1467 Harper Street, Augusta.

CHARLES B. SHIVER, Augusta, has resumed the practice of internal medicine at 1266 Merry Street following two years of service in the U. S. Air Force. Dr. Shiver received his M.D. degree from the Medical College of Georgia in 1949 and served his internship at Fitzsimmons General Hospital and his residency at University Hospital in Augusta. He practiced in Augusta until he was recalled to active duty.

RICHARD TORPIN, Augusta, is vice-chairman of the Georgia Section for the American College of Obstetricians and Gynecologists' Chicago Meeting, November 7-9, 1956.

New MAG Members

Name	Address	Classification	County
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Avery Lon Cotton	817 Columbia Drive, Decatur	Active	DeKalb
William Penn White	112 North McDonough Street, Decatur	Active	DeKalb
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James Lee Cross	1212A Gault Street, S.E., Atlanta 15	Active	Fulton
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James Augustus Redfearn, Jr.	220 Pentz Street, Dalton	Active	Whitfield
Grady N. Coker, Jr.	University Hospital, Augusta	Associate	Richmond
Albert Owen Meredith, Jr.	Dept. of Radiology University Hospital, Augusta	Associate	Richmond
John Washington Looper, Jr.	200 W. Waugh St., Dalton	Active	Whitfield

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The JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and Copyrighted, 1956, by the Medical Association of Georgia, 875 West Peachtree Street, N.E., Atlanta 9, Georgia. Published monthly under the direction of the Council of the Association. Subscription rates: \$5 per year; \$1 per single copy. Entered as second-class mail at the post office at Atlanta, Georgia, under the Act of March 3, 1879. Accepted for mailing for the general rate of postage provided for in Section 1103, Act of October 6, 1917, authorized November 14, 1928.

Journal OF THE MEDICAL ASSOCIATION OF GEORGIA

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COVER

In this month of Thanksgiving, the *Journal* salutes all members of hospital auxiliaries wherever they may serve. Photo by Ted F. Leigh, M.D. (See also page 476.)

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Called MAG Council Meeting

A SPECIAL Called Meeting of the Council of the Medical Association of Georgia was held on October 28 at the request of MAG President Hal M. Davison. Purpose of session was twofold: (1) to formulate a letter of advice on the problem of the ethical practice of medicine, and (2) to deal with the many problems posed in the implementation of Public Law 569, Medical Care for Military Dependents. Other minor matters dealt with included the proposed revision of the American Medical Association "Principles of Medical Ethics," 1956 budgetary items, and MAG employees' unemployment compensation tax. Minutes of this meeting will be published in the December issue of the *Journal* but to inform the members further, a brief summary of the two major items is noted herein.

MAG Ethics

Council unanimously approved a letter of advice regarding the ethical practice of medicine and recommended that it be transmitted to the Richmond County Medical Society along with a legal opinion on the same subject. Because this information concerns component county medical societies, Council recommended that it be sent, as information, to the presidents and secretaries of all MAG component county medical societies. In summary, the last paragraph of the letter states: "It is believed clear from the preceding summary of 'Principles of Ethics' and the reasons for these Principles that the Medical Association of Georgia must not admit to its membership any doctor who condones the corporate practice of medicine whether or not such practice should have been declared by court or legislature to be legal."

It was further clarified that this letter of advice to Richmond County Medical Society is only advice, since each component county medical society is the judge of its qualifications for membership. The legal opinion on: (1) whether or not a corporation may practice medicine in Georgia; (2) whether a different rule applies to a non-profit corporation; (3) whether the contractual return, directly or indirectly, to a corporation by a doctor employee of all or any part of a fee from a pay patient constitutes the corporate practice of medicine; (4) whether the return, directly or indirectly, of all or any part of a fee to a corporation by a radiologist, pathologist or anesthesiologist employed by such corporation constitutes the corporate practice of medicine, and (5) whether or not the Eugene Talmadge Memorial Hospital is practicing medicine by collecting medical fees from pay patients even assuming it is authorized to do so by statute, will also be included with this letter.

Medicare, Public Law 569

MAG Council, in another major action at this called meeting, approved a fee schedule submitted by the Council Committee on P.L. 569 Fee Schedule and gave authority to the following Council representatives to negotiate with the Department of the Army on November 12 in Washington, D. C.: Chairman of the Council Committee on P.L. 569 Fee Schedule, Chairman of

MAG Finance Committee, Chairman of Council or his designated representative, Legal Council, and the Executive Secretary. Others will be appointed if necessary.

Council also voted to have the Executive Committee of Council act as Fiscal Agent to carry out the program, set up a Review Board for the adjustment of claims, and requested legal advice from the AMA on the matter of contractual arrangements. The MAG negotiating team has been scheduled to negotiate all these matters November 12—and data to each physician on the program procedures will be mailed after the MAG and the Army have signed the contract.

Medical Society Accomplishment

Cobb County Medical Society and the Woman's Auxiliary to the Cobb County Medical Society deserve a vote of commendation on their recent "Cavalcade of Medicine." This medical exhibition for the public, held November 11-12-13, 1956, Larry Bell Auditorium, Marietta, told the story of medicine in displays dealing with specific diseases, treatments, x-rays, tissues, and other scientific and commercial exhibits.

To organize such a vast project, stage it, and have it so well received by the public is a tremendous undertaking—and shows the capacity and interest by the medical society in the public welfare. Cobb County Medical Society has shown the people of Cobb County that their physicians are more than fulfilling their responsibility to the community. This unique presentation by Cobb County doctors merits praise from the rest of the profession.

MAG 1957 Legislation Committee

A major undertaking of the MAG Legislative Committee is an amendment to the Georgia Medical Practice Act. The Board of Medical Examiners and the profession working jointly are acting to strengthen existing laws regulating the practice of medicine. Other measures designed to promote better health are under consideration.

You—the individual physician—can render service to the legislators by making information available to them and responding when these legislators seek medical counsel in the interest of the citizenry of Georgia.

On the next two pages are listed the names of State Senators and Representatives. Please tear out and save this information—so that you will know your duly elected representatives.

Hospital Care Study Commission

The Georgia Hospital Care Study Commission will meet November 25 to consider the final draft of the commission's survey and recommendations in regard to the extent of hospital care of indigent sick persons in Georgia. In general, the commission has concluded that the state should assume some of the responsibility of seeing that hospitalization and medical care are available equally to all indigent sick and injured in Georgia.

The Georgia General Assembly

SENATE — 1957 - 1958

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27—	James W. Paris	Winder	54—	Wilton Hill	Reidsville

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Bulloch	Wiley B. Fordham	Statesboro	Clayton	Edgar Blalock	Jonesboro

The Use of Antibiotics in Pulmonary Disease

JOHN H. McCLEMENT, M.D., New York, N. Y.

ALTHOUGH THE ANTIMICROBIAL therapy of most bacterial diseases of the lung is eminently satisfactory, patients are still encountered who have been injured by such treatment. Drug reactions, the emergence of resistant bacteria, recurring infection, and delay in diagnosis of non-bacterial diseases are phenomena frequently reported in connection with the use of antibiotics. A review of diagnostic and therapeutic practices in chest disease may permit one to identify certain basic guides to therapy which will improve the use of antibiotic drugs. To be useful these guides should be applicable in all bacterial diseases of the lung, in tuberculosis, as well as in the various other acute and chronic pulmonary infections. Such a review might also identify areas where our knowledge is incomplete or our therapeutic agents are inadequate and suggest reasons for some failures in the treatment of infectious diseases of the lung.

In Table 1, a scheme for the diagnostic and therapeutic handling of a patient who may require antibiotic treatment for bacterial disease of the lung is suggested. Perhaps such a systematic consideration of the use of antibiotics in every patient will increase the value of these agents and sharpen our diagnostic acumen.

Guides to Antibiotic Treatment of Pulmonary Disease

1. Make an etiologic diagnosis.
2. Identify pathologic character of the lesion.
3. Search for underlying mechanism (e.g., bronchial obstruction, aspiration, bronchiectasis, etc.)
4. Choose best antibiotic and adjunctive regimen.
5. Change antibiotic regimen only for clear indication.
6. Identify irreversible residues and treat if necessary.

Table 1

Presented at the 106th Annual Session of the Medical Association of Georgia, May 13-16, 1956, Atlanta, Ga.
From the Dept. of Medicine, Columbia Univ., College of Physicians and Surgeons, and the Chest Service of Bellevue Hospital.

1. *Make an etiologic diagnosis.* Because of the slow growth of bacteria in artificial media, antibiotic therapy is often started before the infecting agent could have been absolutely identified, and a presumptive etiologic diagnosis must be relied upon. It would be inappropriate in a brief review such as this to attempt to describe the clinical characteristics of the various bacterial diseases of the lung which often permit one to make a presumptive etiologic diagnosis with a fair degree of accuracy from history, physical examination, and simple laboratory examinations. It should be pointed out, however, that bacterial infections of the lung by pneumococci, streptococci, staphylococci, Klebsiella, and tubercle bacilli can usually be diagnosed from an examination of a stained smear of the sputum. While it may be permissible to omit detailed bacteriologic studies when one treats a patient with a typical uncomplicated acute bacterial pneumonia in his home, appropriate material should be obtained for bacteriologic examination before one starts antibiotic therapy in the patient with atypical, severe or obviously complicated pneumonic disease.

2. *Identify the pathologic character of the lesion.* The bacteria that invade the lung have a capacity to produce a variety of inflammatory lesions. These may vary from the acute, readily resolvable exudative lesion usually encountered in early pneumococcal pneumonia, to the necrotic, sloughing, poorly drained process seen in abscesses caused by anaerobic organisms. The former can be treated briefly with reasonable expectation that no significant residue will remain; the latter requires prolonged therapy, bronchial drainage must be established, and significant irreversible residues are to be expected. An early attempt at careful characterization of the pulmonary process in pathologic terms often helps one to visualize a complete program of therapy.

3. *Search for underlying mechanism.* On every active chest service, patients are frequently encountered who have bacterial infection of the lung secondary to bronchial obstruction or some aspirational mechanism and who have been given antibiotic therapy without the underlying mechanism being identified. Sometimes identification of such a mechanism is difficult but often the physician who started treatment would have diagnosed the underlying condition if he had even considered the possibility. The pneumonia behind a bronchial tumor or an aspirated foreign body can often be improved by the use of antibiotics, but such treatment should not, as it often does, delay recognition and definitive therapy of the underlying cause.

4. *Choose the best antibiotic and adjunctive regimen.* If an exact etiologic and pathologic diagnosis has been established, the choice of antibiotics is usually fairly simple. Infection with pneumococci and Group A hemolytic streptococci are readily treated with penicillin or tetracycline. Staphylococcal or Friedlander infections may require more ingenuity and the use of prolonged combined therapy. Previously untreated tuberculosis is probably best treated with a prolonged regimen using isoniazid and one of the other tuberculostatic chemotherapeutic agents.

The choice of an antibiotic regimen when an etiologic diagnosis has not been established is sometimes difficult. Because most bacterial infections of the lung are still caused by penicillin sensitive organisms, this agent should probably be used in most cases where an etiology has not been established. If infection with gram negative organisms is suspected, or the infection seems life endangering, penicillin should be supplemented with full doses of streptomycin, until an exact bacteriologic diagnosis is made. Because the use of streptomycin in this way may interfere with the subsequent diagnosis of tuberculosis, its use should be avoided where tuberculosis seems likely until adequate material has been obtained for culture for tubercle bacilli. The tetracycline compounds can be used instead of penicillin in some of these undiagnosed cases. Chloramphenicol should be reserved for specific indications, because of its infrequent association with blood dyscrasias. Erythromycin should be saved for resistant staphylococcal infections.

The planning of a therapeutic program should not stop with the choice of proper chemotherapy, and one should search for adjunctive measures that may be helpful. The emphysematous patient with broncho-pneumonia may be helped as much by the judicious use of bronchodilators as by the ingestion of tetracycline. Pneumococcal empyema responds quickly to drainage and may be benefitted little by parenteral penicillin.

5. *Change antibiotic regimen only for clear indi-*

cation. Once started, a reasonable antibiotic program should be adhered to until infection has been completely controlled or evidence is available that the regimen being used cannot accomplish this. With pneumococcal infections, control of infections may be achieved in a few days; in the chemotherapy of tuberculosis months and even years of treatment may be best.

Needless changing of antibiotic regimens increases the chances of drug reactions and multiplies the possibility of resistant organisms appearing. The finding of a new insensitive bacteria in sputum is not in itself evidence of infection by that organism and is not sufficient reason for altering therapy. Clinical evidence of infection in the clinical course, appearance of secretions, and the abundance of the organism in these secretions must be sought for before therapy is changed. Tuberculous patients are frequently seen with tubercle bacilli resistant to all the more potent antituberculous drugs. It is sometimes found that these patients have been changed from one drug regimen to another in a most whimsical and injudicious fashion. Changing the drug regimen of a tuberculous patient is a major step and requires most careful consideration.

6. *Identify irreversible residues and treat if necessary.* Many cases of advanced pulmonary tuberculosis will be salvaged only if resectional or other surgery is employed for the dangerous irreversible residues. Criteria for assessing these residues and their capacity for causing progressive disease are still being evolved. Clinicians, unfortunately, cannot wait for the long follow-up that will be needed to define just which of these residues need to be resected and which may be left untouched. When careful clinical and laboratory examinations indicate that little further improvement in the tuberculous process is to be expected, the clinician must by every means at his disposal attempt to characterize the residual lesion in pathologic terms, and estimate its capacity for eventually leading to recurring disease.

The residual defects which remain after infections with other tissue destroying organisms deserve similar detailed evaluation after antibiotic therapy. The capacity of many such residual lesions to cause further disability may be fairly slight.

Chemoprophylaxis

No discussion of the antibiotic treatment of pulmonary disease would be complete without mention of the prophylactic use of these substances. A large portion of the drug industry's output of these compounds is used for attempted prophylaxis. In extrapulmonary fields studies¹ have shown that prophylaxis against gonococcal, beta-hemolytic streptococcal, meningococcal infections and bacillary dysentery is feasible. Observations² on the prophylaxis of bac-

State Board of Health Meets

REPORTS ON HEALTH APPROPRIATIONS, proposed legislation, polio immunizations and progress in the new health district plan and hospital construction were heard by the State Board of Health in the meeting on October 16 at the Georgia Department of Public Health, State Office Building, Atlanta.

In election of new officers, Fred H. Simonton of Chickamauga succeeded R. L. Rogers, Gainesville, as Chairman of the Board, and J. G. Williams, Atlanta dentist, became vice chairman, succeeding J. M. Byne, Jr., Waynesboro. They will serve 18 months.

The State Health Department will have state, federal, and other appropriations totaling \$18,137,234 during fiscal year 1957 (July 1, 1956-June 30, 1957), according to Mr. Ernest B. Davis, State Health Department Treasurer. Mr. Davis said about six million dollars of the appropriations will be spent in general public health work.

Proposed legislation read to the Board by S. C. Rutland, director of Local Health Services, included an amendment to the law under which tuberculosis victims are committed to Battey State Hospital allowing patients to take emergency leave under conditions which would not endanger public health.

Proposed milk and food service sanitation bills would provide uniform state-wide standards in the inspection of dairies and food service establishments. Each county would observe the basic regulations of the State Board of Health in issuing or removing operating permits for these establishments.

The \$10,000 limit on the salary of the Director of

the Georgia Department of Public Health would be removed by another proposal allowing the Board to set his salary, with the approval of the State Budget Bureau. Also, an increase from seven dollars to 20 dollars will be sought in the meeting day expense payment to Board members. This is the amount paid in many other states.

John H. Venable, assistant to the Director of the State Health Department, said only nine cases of paralytic and 20 cases of non-paralytic polio had been reported in Georgia through September of this year among the 545,000 between six months and 20 years of age who have received two shots of Salk vaccine. Dr. Venable said it appeared that two vaccinations prevented many of those infected from developing paralysis.

Of the 38 proposed new health districts in the state, 15 are already active, providing 49 counties with full public health coverage, according to Dr. Rutland. He said that seven other districts are ready to become active, serving 24 counties.

Four new hospital construction projects under the federal Hill-Burton Act of 1946 were announced for the coming year by R. C. Williams, director of Hospital Services for the Georgia Health Department. The projects are in Wayne, Gwinnett, Walton, and Paulding Counties. There will be enlargement projects at Kennestone Hospital, Marietta, and City-County Hospital, LaGrange. Dr. Williams said Georgia must continue adding 500 hospital beds yearly just to stay at the present level, which even now is about 4,000 beds under the state's actual needs.

The Use of Antibiotics in Pulmonary Disease (cont'd)

terial infection of the lungs of patients with respiratory paralysis from poliomyelitis seem to indicate that in this group of patients, at least, infection occurred nearly as often when antibiotics were given, as when they were withheld and that satisfactory chemoprophylaxis for all pulmonary infection cannot be achieved with our present agents used in a variety of different combinations. The infections which can be most consistently prevented by antibiotic treatment are those caused by very sensitive organisms, and these are readily treated whenever infection becomes apparent. For these reasons the widespread use of antibiotics for chemoprophylaxis of pulmonary infection does not seem justified at the present time. Even though carefully controlled studies are not available, clinical observations seem to indicate that the incidence of bronchopleural fistula after pulmonary resection has been decreased by a brief period of post-

operative antibiotic treatment. The use of antibiotics in the long-term management of chronic pulmonary emphysema needs more systematic study.

Summary

In this brief review an attempt has been made to identify certain diagnostic and therapeutic steps which will improve our use of antibiotics in pulmonary infection. It seems clear that careful diagnosis, rational therapeutics, and continued research must be maintained if full benefit is to be obtained from these agents.

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Round Back in Children

ALBERT B. FERGUSON, JR., M.D., Pittsburgh, Pa.

SINCE THE ADULT with increased dorsal kyphos, tender interspinous ligaments, and dorsal spine discomfort is a fairly common clinical entity, we were interested in looking into the childhood group to find possible causes for this type of spine deformity.

A review of youngsters with increased dorsal round back reveals several possible causes. The upright posture is common to them all. Obesity can increase this mechanical stress. So can tight hamstring musculature—the child with tight hamstrings being forced to flex excessively in the dorsal spine on attempting to reach to his toes without bending his knees. This is a common between period exercise in school and may actually promote dorsal round back.

So called Schmorl's nodes can undoubtedly be implicated. Such nodes are not herniations of the intervertebral discs into the body of the vertebra. Close inspection reveals that the walls and base of these nodes are straight—the base being flat. Specimens of the lesion reveal that they are cartilaginous and represent an area of failure of the epiphyseal plate to undergo normal ossification. As a corollary to this disturbance the growth rate is diminished, and anterior wedging of the vertebra results when the node is located anteriorly. A failure of epiphyseal cartilage to become converted to normal bone and a diminished rate of growth are both characteristic of chondrodysplasia.

Irregular ossification of the vertebral epiphyses themselves has been implicated as a primary cause of the deformity. Such irregularity may be due to altered stress anteriorly on the vertebral plate, however. Round back deformity and wedging can occur before the appearance of ossification in these growth centers.

Anterior vascular grooves which are persistent may be another cause of vertebral wedging. Closure may take place by collapse of the groove rather than by filling in with bone. If this is so, then the child in the six to 10 age group, before the appearance of irregular ossification in the epiphyses and the marked wedging and physical findings that are associated with Schuermann's disease or kyphosis juvenilis in the teen age group, deserves attention to protect him

from the development of deformity. It is not felt that every child with persistent grooves will go on to vertebral deformity.

Normal Spine Development. A review of unselected lateral chest films in which the dorsal spine was shown reveals that the normal dorsal kyphos is principally in the proximal portion of the spine at the fifth, sixth, and seventh thoracic vertebrae. It was also found that the anterior vascular grooves of the vertebra close during the seven to 10 year age group. Thirty per cent of the patients examined (153 cases) had persistent grooves in the seven to eight year group. Seventeen per cent were still persistent in the nine to 10 year age group. By the time the age of 11 was reached, such grooves as could be discerned had vestigial openings only.

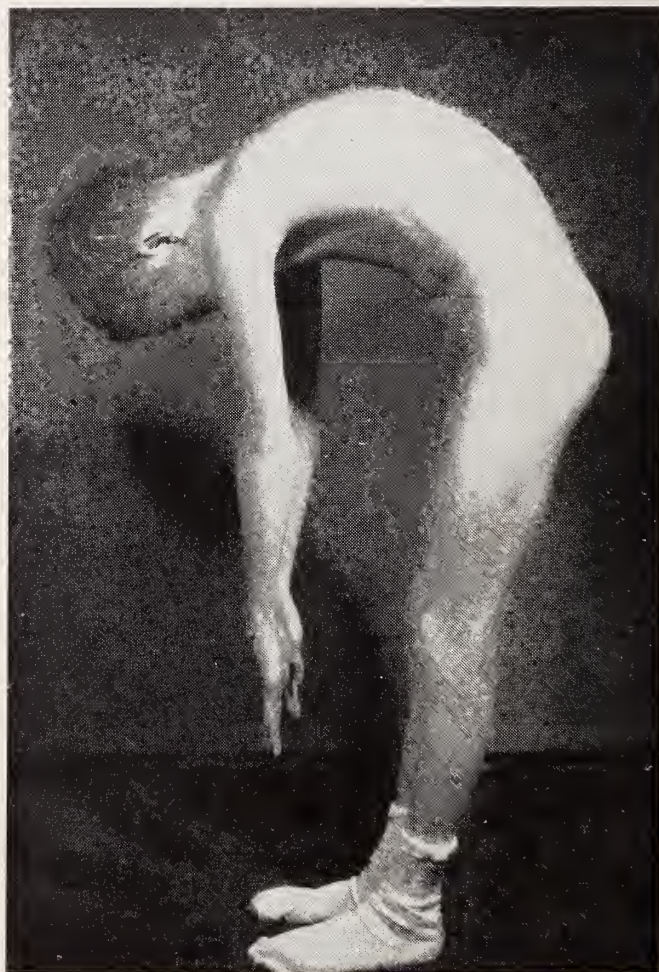


Figure 1

Flexion of spine accentuated in lower dorsal area due to limitation on forward bend imposed by tight hamstrings. (From *Pediatric Clinics of North America*, Nov. 1955.)

PERSISTENT ANTERIOR VASCULAR GROOVE

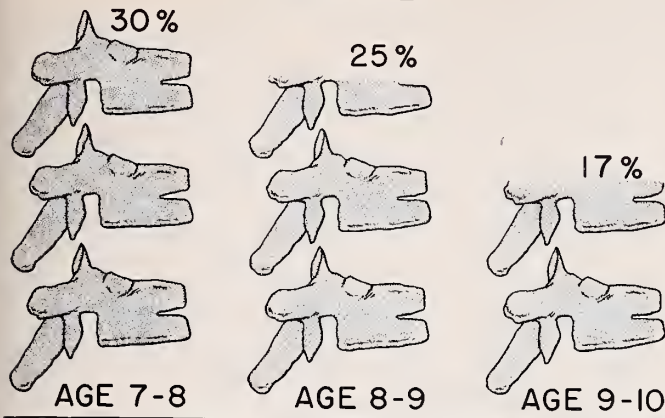


Figure 2

Diminishing incidence of persistent anterior vascular grooves in the seven to ten year age group. (From *Jour. Bone & Joint Surg.* 38A, 14-157, Jan. 1956.)



Figure 3

Skeleton of dorsal vertebra showing open vascular groove—in general the wider the groove the more deeply it extends into the vertebra. (From *Jour. Bone & Joint Surg.* 38A, 149-157, Jan. 1956.)

Anatomy

Dissection reveals that these grooves are filled by a large endothelial lined blood lake caused by a confluence of vessels at this point. The width of the grooves across the anterior face of the vertebra varies with the degree to which it is open. When only a small opening remains, in the lateral roentgenogram the anterior face of the vertebra is well supported.

A review of 21 cases in which definite persistent anterior vascular grooves were noted revealed progression in 18. All but two of these patients were in the five to 12 year old age group. The vast majority had been followed for at least three to four years.

Eight additional cases were seen with established round back deformity. Seven of these showed some evidence of persistent grooves. One was entirely negative. Wedging sometimes obliterates the grooves. One can occasionally see a dense line of overlapping trabeculae in the center of the vertebra, suggestive of the prior existence of groove which has been obliterated by wedging.

When a round back deformity exists, it is apparent



Figure 4

Wedging of vertebra anteriorly irregular ossification at the epiphyseal plates and remnant of anterior vascular groove in central vertebra of curve. (From *Jour. Bone & Joint Surg.* 38A, 149-157, Jan. 1956.)

that it is formed by the addition of wedging below the fifth to seventh dorsal vertebrae. Such wedging in these lower vertebrae is sufficient to give a noticeable increase in the dorsal kyphos when added to the normal wedging above.

Treatment

The point of this paper is to advance the age at which treatment is undertaken for developing round back deformity and not limit it to the classical teen age disease. Persistent anterior vascular grooves appear to be a forerunner of the deformity in some cases. When this is a roentgen finding and poor posture is evident clinically, treatment appears to be indicated until these grooves have filled in. Presumably at this point, progression is no longer possible. Associated growth disturbances, such as Schmorl's nodes, would invalidate that statement if full growth has not been attained.

Excessive stress on the dorsal spine such as is caused by forward bending exercises, habitual sitting attitudes, and obesity should be eliminated.

Excessive lumbar lordoses should be combatted by pelvic tilt exercises and by a lumbar spinal flexion

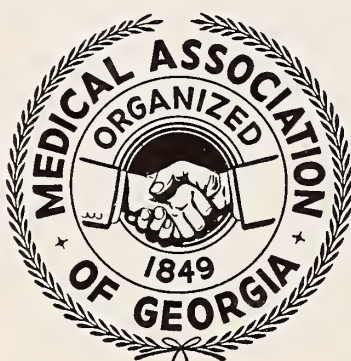
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Round Back in Children (cont'd)

brace. This brace encompasses the lumbar spine only and is built to flatten the lordosis. Improvement in dorsal spine posture and removal of stress from the anterior portion of the dorsal spine bodies is a secondary result.

Periods of recumbency, elimination of the pillow, use of a bed board, stretching of the hamstrings, and erector spinae exercises help. With a well established deformity, wedging jackets and even spinal fusion may be indicated.

Summary

The fact that round back deformity is due to wedging below the area of normal dorsal kyphosis at

D-5 to D-7, and additive to it has been emphasized as well as the preventive medicine that may be practiced by procuring roentgenograms of the dorsal spine of the child with poor posture early round back deformity and protecting the dorsal spine in those children exhibiting persistent open anterior vascular grooves in the dorsal vertebrae.

125 De Soto Street

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Electrocardiography: Its Uses and Abuses

BERNARD S. LIPMAN, M.D., Atlanta, Ga.

WITHIN RECENT YEARS rapid progress in the field of cardiology has given the electrocardiogram a degree of importance it has not attained in the past. The swift pace of progress in cardiovascular surgery, particularly, has not only affected the internist and cardiologist, but also the pediatrician, the obstetrician, the anesthetist, as well as the surgeon. All have realized the necessity and importance of an adequate knowledge of cardiovascular diagnostic procedures in correctly identifying congenital and acquired lesions preoperatively. The value of a diagnostic procedure, whether the electrocardiogram, x-ray, fluoroscope, cardiac catheterization, angiogram, ballistocardiogram, or blood analysis, is directly proportional to the ability and skill of the individual who performs and interprets the test. It is not only important to have a knowledge of the uses of the procedure, but it is equally and possibly more important to know the limitations of the procedure. It should be remembered that a solid body of knowledge in electrocardiography is based on empirical data. There is also a large area which has developed from purely theoretical consideration, and over a period of years these long accepted theories have become entrenched as a truth even though they have not been validated by experiment. In this paper, the abuses and pitfalls of the electrocardiogram will be emphasized; its uses will be mentioned only briefly.

The human heart electrocardiographically may be compared to an electric pump, and defects may be divided grossly into two categories: (1) defect in the wiring, and (2) defect in the pump itself. Under "wiring defects" may be classified the various types of arrhythmias, first, second, and third degree heart block, bundle branch block, and Wolf-Parkinson-White Syndrome. "Pump defects" may be classified as pericardial, myocardial, or endocardial abnormalities.

The electrocardiogram has proved to be particularly useful in the diagnosis of the "wiring defects," referring to conduction disturbances. In regard to disorders of the pump itself, the electrocardiogram has been helpful in the diagnosis of ventricular hypertrophy, myocardial damage (ischemia, injury, infarction), myocarditis, pericarditis, pulmonary em-

bolism, electrolyte imbalances, ventricular aneurysm, drug therapy (digitalis, quinidine), myxedema, postpartum myocardosis, and various other isolated conditions and specific diseases. No attempt is made to include all the conditions in which the electrocardiogram may be of use. It should be emphasized that in the conditions mentioned above, oftentimes there is a series of gradations or developing changes correlated with the stage of the disease so that the fully developed electrocardiographic picture is not present. Moreover, a 100 per cent agreement between anatomic and electric abnormalities does not occur.

The abuses and pitfalls encountered in electrocardiography may be divided into (1) extracardiac factors, (2) twilight (borderline) electrocardiograms, (3) iatrogenic abuses, and (4) miscellaneous pitfalls. Under extracardiac factors there are many possible sources of error. First, the machine itself

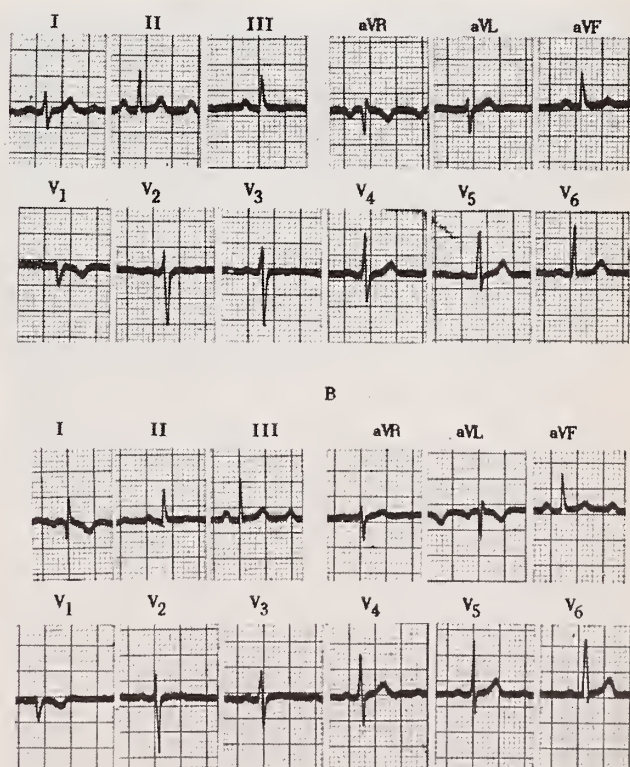


Figure 1

Reversed electrodes. A. Normal record with electrodes in the proper order. B. Taken with the right and left arm electrodes reversed. Lead I is mirror image of itself. Leads II and III are reversed as are leads aVR and aVL. The chest leads and aVF are the same.

may be faulty and technically inadequate, particularly the direct writer machines. The technician may be guilty of making faulty tracings by reversing the electrodes (Figure 1), standardizing the machine incorrectly, placing the chest electrodes on the wrong site, permitting the electrode jelly to run together in the various precordial leads, or mounting the electrocardiograms upside down or in wrong order. The thickness of the chest wall and the distance from the heart to the chest wall may also alter the electrocardiogram. It is important to keep in mind the fact that the various body tissues are heterogeneous in the ability to conduct electric currents. Pleural effusion or pericardial effusion will short circuit the current and produce low voltage. Skin resistance and polarization are other possible extracardiac sources of error. Drugs such as digitalis (Figure 2) and quinidine, infections, fever, pain, fear, shock (Figure 3), eating, and temperature changes, such as drinking a glass of iced water prior to taking the electrocardiogram, may produce specific electrocardiographic alterations per se. Electrolyte disturbances (Figure 4) and various diseases among which are included myxedema, scleroderma, amyloidosis, Chagas disease, diphtheria, and others may produce electrical changes which should not be overlooked.

Twilight or borderline electrocardiograms occur

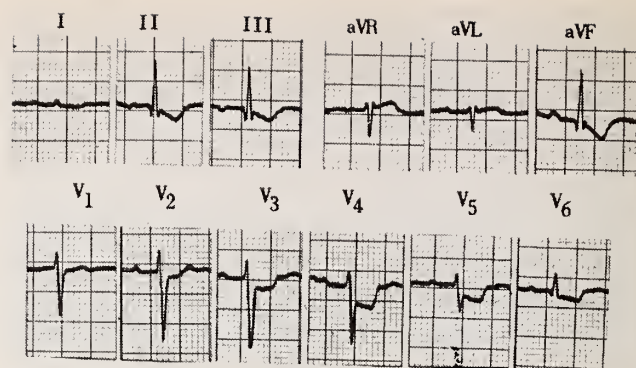


Figure 3
Subendocardial injury resulting from shock. With correction of the shock state, the tracing reverted to normal.

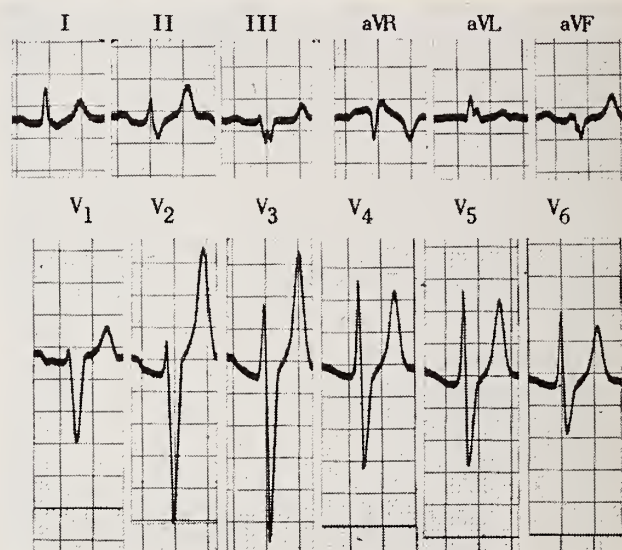


Figure 4
Characteristic changes of hyperpotassemia in an uremic patient with chronic glomerulonephritis. Note the high peaked T waves in the precordial leads, I, II, III, and aVF. The introventricular conduction time is full (0.10 sec.)

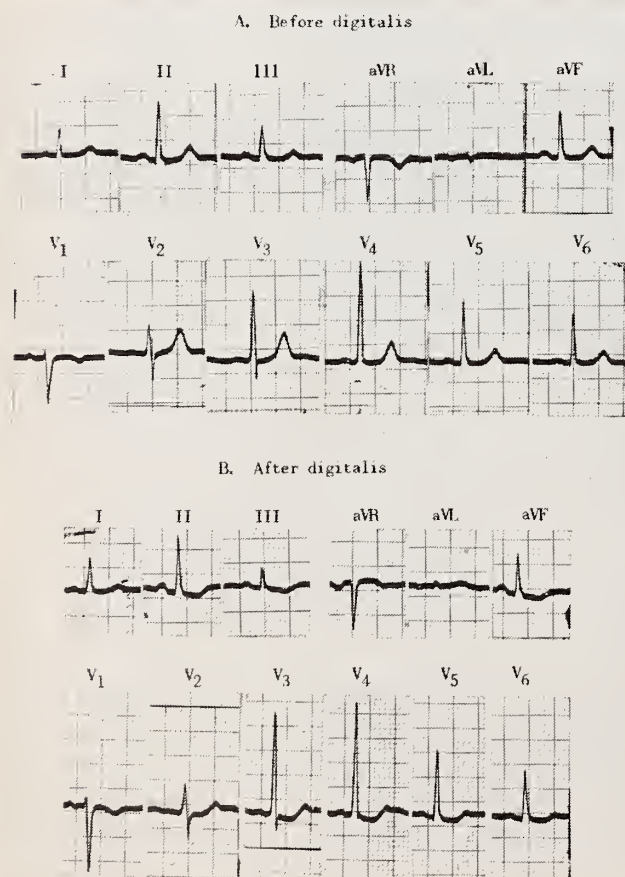


Figure 2
Digitalis effect. A. Before digitalis. B. Typical S-T and T wave changes due to digitalis.

frequently and may be difficult to interpret. In infants, the electrocardiogram normally demonstrates right ventricular prominence so that definite right ventricular hypertrophy may be difficult to identify. This is important in congenital heart disease. Other borderline cases which may confuse the interpretation occur in mild left ventricular hypertrophy or "strain," biventricular hypertrophy, and borderline S-T and T wave changes in cases of coronary artery disease. By iatrogenic abuses is meant those cases in which the interpreter is at fault. Reading too much into an electrocardiogram is as faulty as overlooking significant alterations. An incorrect diagnosis of coronary artery disease on the basis of minor T wave and S-T segment changes occurring in association with atypical chest discomfort can be disastrous. It is extremely hazardous to utilize the electrocardiogram as a basis for a prognosis; neither should the electric activity of the heart be used as a basis for making an etiologic diagnosis. The overemphasis of a meaningless arrhythmia can produce a cardiac invalid unnecessarily. Premature contractions, bundle

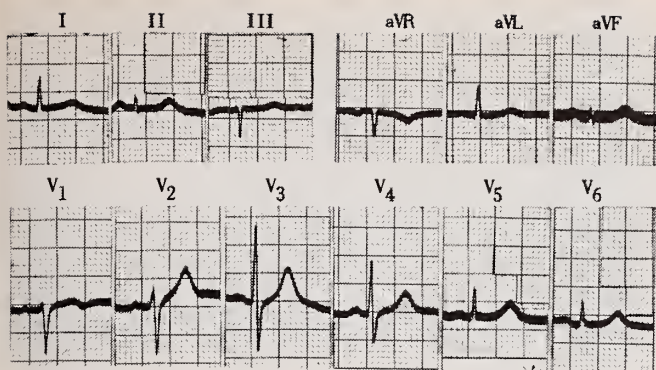


Figure 5
Record taken in Emergency Room on patient shortly after onset of persistent retrosternal oppressive pain. Within normal limits.

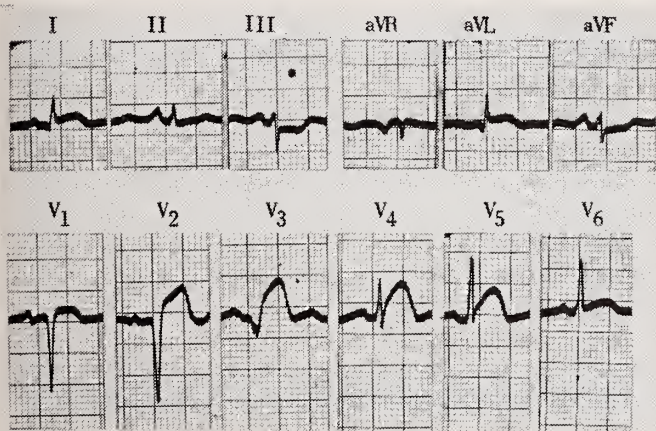


Figure 6
Same patient as Figure V. Record taken four days after onset of pain. Anterior myocardial infarction.

branch block, and paroxysmal tachycardia should be evaluated in the light of the entire clinical picture; a patient should not be stigmatized with a diagnosis of heart disease on the basis of the arrhythmia alone. It is most unfortunate to overlook a so-called "silent" infarction, the patient without chest pain who suddenly collapses. It is equally disastrous to reassure the patient with coronary artery chest pain who fails to show electrocardiographic changes, the so-called "circumstantial" infarction. There are occasions when a patient may present clinical characteristics of a coronary occlusion; yet the electrocardiogram fails to confirm the diagnosis. The reassurance of such an individual on the basis of the normal electrocardiogram should be postponed for several days until serial electrocardiograms have been taken and a myocardial infarction has been ruled out (Figures 5 and 6). Another possible pitfall is the "masking" of an infarction by the presence of a left bundle branch block or the presence of two infarcts with counteracting electric forces such as occurs when an acute posterior infarction is superimposed on an old antero-septal infarction. One of the worst iatrogenic atrocities is to utilize the electrocardiogram as a "push button" instrument. To request an electrocardiogram as a substitute for cardiac consultation is obviously

foolhardy; yet there are times when a surgeon will order an electrocardiogram to be taken prior to surgery to check the patient's "cardiac status". The electrocardiogram cannot fashion a "push button" diagnosis.

Other possible pitfalls and sources of confusion may occur in the differentiation of pericarditis from infarction, particularly when the patient may be first seen several days after the episode of chest pain (Figure 7). Pulmonary embolism may be mistaken for an inferior or posterior myocardial infarction. The changes seen in ventricular aneurysm are not to be confused with an acute myocardial infarction (Figure 8). The importance of serial electrocardiograms cannot be overemphasized. It has been demonstrated recently that a type of S-T segment elevation occurs normally and should not be confused with pathological S-T segment elevation (Figure 9). Isolated T wave negativity in lead V_4 or V_5 may also lead to an incorrect diagnosis of coronary artery disease (Figure 10). Another possible source of confusion is the differentiation of an old antero-septal infarction from left ventricular hypertrophy. To stigmatize a

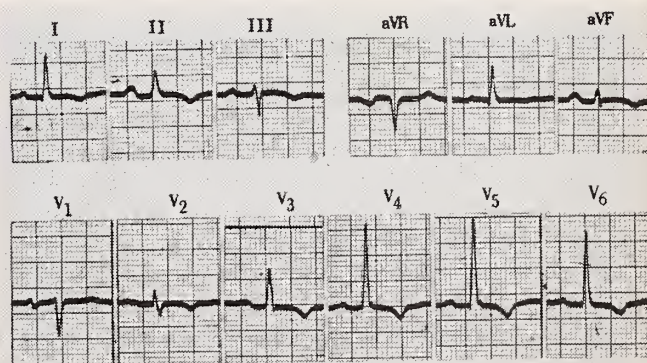


Figure 7
Pericarditis. Note shallow inverted T wave in I, II, III, aVL, aVF, V_2 through V_6 . This could easily be confused with myocardial ischemia due to coronary artery disease. History and physical findings are most important.

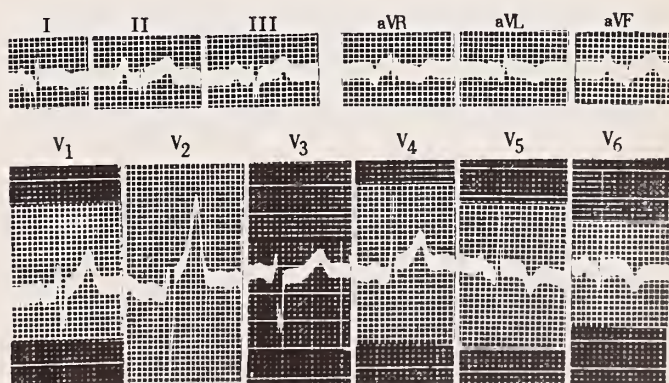


Figure 8
Ventricular aneurysm proved at autopsy. Note the significantly bowed S-T segments in V_5 and V_6 . The S-T segment changes in V_5 and V_6 are not pathognomonic but are suggestive of aneurysm when persistent over a prolonged period of time. Such changes are not to be confused with an acute myocardial infarction.

Handicapped Children

THE GEORGIA CONFERENCE on Handicapped Children will be held in Atlanta at the Dinkler Plaza Hotel on November 29 and 30, 1956. This is the first such conference ever held and is of vital interest in the present and future of the State of Georgia. This meeting was called by the Division for Exceptional Children, State Department of Education, and is sponsored by The Better Health Council of Georgia; complete financial support for the conference is generously provided by the Nemours Foundation, Wilmington, Delaware, a charitable corporation for advancement of work with the handicapped child.

There will be three sessions: at 1:00 p.m. Thursday, November 29; 9:30 a.m. Friday, November 30; and the final session at 1:30 p.m. Friday, November 30, 1956. There will be no registration or admission fees. The major objectives of the sessions are (1) to hear a specialist-investigator disclose and comment

on the Georgia Study of the problem of handicapped children; (2) to evaluate available sources for meeting the needs of the handicapped in Georgia; (3) to determine the un-met needs for a program of adequate care for the handicapped child; and (4) to chart the course for a co-ordinated program for the handicapped children of the state.

Among the nationally known speakers will be Samuel M. Wishik, M.D., Director of the Georgia Study, Department of Maternal and Child Health, Graduate School of Public Health, University of Pittsburgh; Katherine Bain, M.D., Assistant to the Chief for Program Development, Children's Bureau, U. S. Department of Health, Education and Welfare, Washington; M. A. Perlstein, M.D., Past President of the American Academy of Cerebral Palsy, Chicago; A. R. Shands, Jr., M.D., Medical Director, Alfred I. du Pont Institute of the Nemours Foundation, Wilmington, Delaware; Paul Moore, Ph.D.

All Georgians interested in handicapped children are invited and urged to attend these session.

Electrocardiography (cont'd)

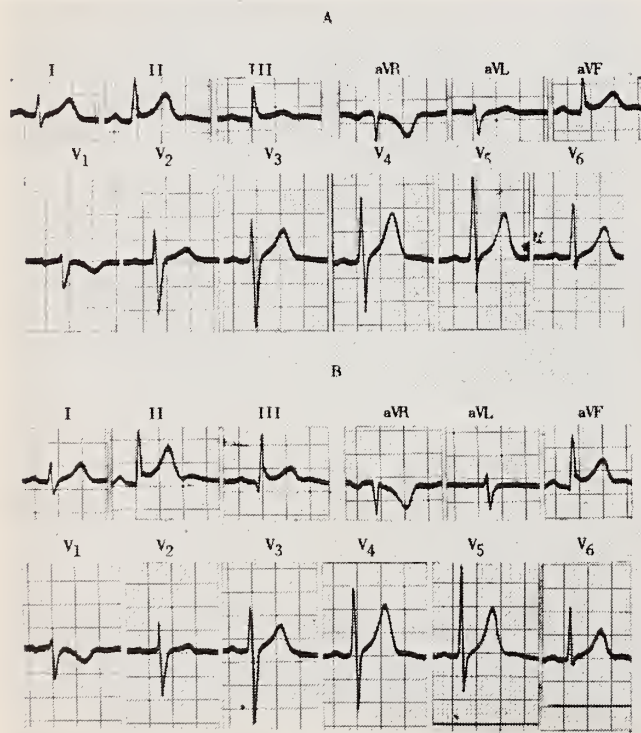


Figure 9

Normal S-T segment shift. A and B records taken two weeks apart on a patient without heart disease. The S-T segments in II, III, and aVF at first glance appear abnormally elevated but are within normal physiological limits when compared with the following sloped T-P base line.

patient mistakenly from electrocardiographic evidence with a diagnosis of coronary artery heart disease can produce such a severe psychological and economic hardship that the patient may never recover.

The electrocardiogram is like a double edge sword

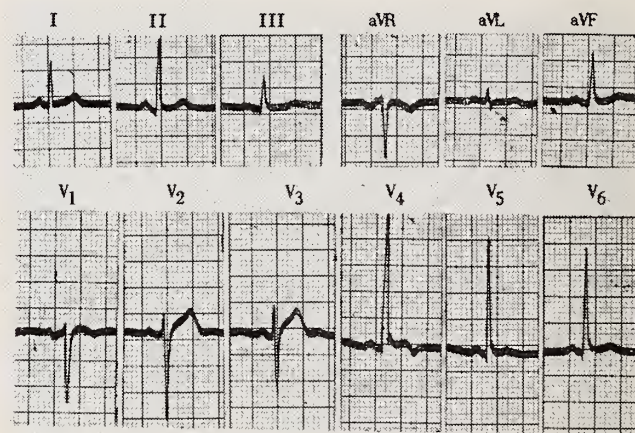


Figure 10

Isolated T wave negativity over apex of heart (V_4) in a patient with no clinical or laboratory evidence of heart disease.

and can do as much harm as good. Electrocardiography has many pitfalls. If the proper perspective is maintained by correlating a careful clinical history with a thorough physical examination and with other laboratory data, the electrocardiogram when used intelligently and judiciously can prove to be a most valuable diagnostic adjunct.

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Military Problems and the Civilian Physician

MAJ. GEN. SILAS B. HAYS, M.S.A.M.C., Washington, D. C.

I WISH TO EXPRESS my appreciation to the officers of your association for inviting me to participate in your annual meeting and for the hospitality all of you have extended to me.

I welcome the occasion to make new friends and to renew the old and valued friendships made in the past. I appreciate this opportunity to discuss with you some of the problems which confront those of us in the military service, and the Army Medical Service particularly.

My talk is directed toward military problems and the civilian physician. I propose to discuss with you matters which are of mutual interest and which are of concern to you as individuals and your association generally, as well as being of vital importance to the military services. The solutions to these problems are not readily discernible or easily achieved, but I earnestly hope that such meetings as this will promote and reinforce that splendid spirit of cooperation which has been so valuable in the past. It is only through a complete and up-to-date knowledge and understanding of what we are up against, and the exchange of information and ideas, that we will be able to come up with the best answers.

The handling of mass casualties, for example, in recent years has been a subject of great concern to doctors both in civilian practice and in the military service.

The medical problems involved in the handling of disasters are of general interest and in need of continuing study and review. In recent years, many of our communities have suffered sudden catastrophe with significant loss of life and property calling for the rapid mobilization of all local medical resources and additional support from state and federal agencies. In retrospect, careful analysis has pointed out important deficits in their management during the early hours, many of which might well have been obviated by more effective organization and coordination of effort under authoritative leadership.

It is commendable that in no instance was there any lack of willingness to help, for public response was prompt; in fact many areas were quickly over-

run with volunteer help which seemingly paralyzed the more orderly activities. Transportation lanes were blocked, communication lines were overloaded, and in some instances such professional undertakings as the collection of much needed blood were ineffective through lack of adherence to established principles. Whereas it is recognized that whenever disaster occurs there invariably will be mistakes made, it is from such studies that lessons may be learned and corrective action taken in all future planning and organization.

Today our nation is faced with the necessity of encouraging a general familiarization with the problems relating to atomic or nuclear warfare. It must be apparent that if these devices were employed in an attack on this country, their destructive potential is such that the medical problem created in the early days and weeks would far exceed our immediately available medical resources to care for all surviving casualties in accordance with accepted standards. This is of concern to the civilian profession as well as the military. War may be directed toward industrial centers which by their very nature are heavily populated. Furthermore, if several areas were attacked simultaneously it is reasonable to infer that our medical resources would be divided accordingly. It should be recalled also that the primary duty of the military medical services will be in support of the military forces in carrying out the mission of defense of the nation and successful retaliation. Under such conditions, it is apparent that those communities adjacent to a target area must be prepared through planning and organization to take over the responsibilities of care for the survivors not only in terms of food and shelter but by rapid mobilization of medical teams to render first-aid and survival care.

Based upon past military experience, analysis of major civilian disasters and critical study of the results of the atomic attacks on Hiroshima and Nagasaki, we are now able to point out several important conclusions which apply to the medical management of mass disaster in atomic warfare, many of which are equally applicable to any natural disaster in which a mass casualty situation develops. By a mass casualty situation I mean one in which the number of

Presented at the 106th Annual Session of the Medical Association of Georgia, May 13-16, 1956, Atlanta, Ga.

injured exceeds the medical resources which can be brought to bear. A relatively small disaster in which one doctor had to care for 50 surviving casualties would, relatively speaking, be the same mass casualty situation as an atomic blast which left 100 doctors to care for 5,000 casualties.

(1) There will be a marked deficit between the available medical resources, particularly physicians, and the medical workload.

(2) The professional objective during the early hours or days must be to direct all effort toward doing the best possible for the greatest number of lives will be saved and restored to some degree of effectiveness.

(3) All professional personnel must be utilized in the treatment of injuries and not be wasted in rescue procedures, evacuation of patients, or welfare activities.

(4) The medical problems are primarily those of mechanical injuries and burns. All physicians therefore will be caring for wounds, and their effectiveness will be determined by their familiarity with such techniques.

(5) Surgeons with experience in the management of trauma will be directing the less proficient rather than operating themselves.

(6) Priorities for care must be promptly established with a knowledge of the fact that many minor injuries will recover without professional medical care, and acceptance that there will be those who are hopelessly injured. Life-saving procedures must be given priority over those which may be deferred without reasonable jeopardy to life and limb.

(7) Hospital facilities must be so organized that there will be controlled admission and rapid evacuation. All available bed space and functioning personnel must not become paralyzed by comparatively minor injuries or patients in need of post-operative supporting measures who logically could be cared for elsewhere.

(8) Surgical teams within the hospital must be organized, for with fatigue efficiency diminishes. In the first days surgeons must carry out simple techniques only and be mindful that no undertaking should further reduce a casualty's opportunity for better definitive care at a later date.

(9) Lines of communication, x-ray and laboratory facilities, medical supplies including blood, intravenous fluids, antibiotics, and perhaps power and water may be lacking during this critical period. Innovation and substitution will be necessary in many instances until reorganization and stabilization have been effected. Economical utilization of all supplies will be mandatory.

(10) The penalties of delayed or inadequate care must be assumed. If one is to accomplish the best possible for the most under such adverse conditions, professional judgment must be sound and prompt, with the problems of deformity and disfigurement considered to be those of another day.

When one thinks in terms of thousands of casualties, many of whom have multiple injuries and for whom there is a temporary appalling deficit of medical personnel and supplies, it must be realized that to effect maximum survival, considerable adjustment in our planning must take place. Perhaps most important of all is the necessity that we encourage widespread training programs in first aid and survival care. It is encouraging that more recently there has been an increasing interest in the management of trauma and its prevention. Medical schools, intern and resident programs, national professional societies, and research institutions are devoting more and more time to this subject. At present 25 medical schools have adopted the MEND (Medical Education for National Defense) program, and others express an interest. The individual's ability to care for himself or his neighbor may be the sole source of immediate help should we become involved in an atomic war. Military training programs for the enlisted man and officer alike have been modified to include such instruction. If it be our good fortune that all threats to war be effectively quarantined, such training in emergency care will still be invaluable, for highway and home accidents exceed 10,000,000 yearly, and fires, floods, and tornadoes still plague our nation.

I am sure all of you are well aware of the situation of the armed forces medical services in regard to a need for more career medical personnel. The seriousness of this matter has long been of concern to the AMA and state associations, but today I want to point out that this problem is not peculiar to the Active or Regular Army.

The citizen-soldier has been, is, and will continue to be, a part of our American heritage. In each national emergency and in every major conflict, our citizen-soldier has been asked to lay aside his civilian endeavors and don the uniform of our armed forces, to fill the gap between the deployment of the active Army on and after beginning of mobilization and the time when the organization, training, equipping, and deployment of new additional forces have been completed. In order to meet these initial mobilization requirements, some, and parenthetically all too few, of our citizen-soldiers are organized into units which comprise the Ready Reserve forces.

The voluntary reserve program was not as successful as hoped, and fell below what was considered by

the President to be a minimum for the security of our country. Consequently he requested the Congress to enact legislation to bolster our reserve program.

Last August (1955) the President signed *Public Law 305* which is referred to as the "Reserve Forces Act of 1955." It permits young draft eligible men, under 26 years of age, to enlist in the Army for two years, then participate in a Ready Reserve status for three years and remain on the rolls as a Stand-By Reserve for one year. The total military obligation is six years; whereas, under the old law, the total obligation was eight years.

This law also provides for male individuals 17 to 18½ years of age to enlist in a local Reserve unit. After enlisting, they are sent to a training center where they receive eight weeks of training in the role of a combat soldier. At this point, dependent upon the type of unit they enlist in, they receive individual training in a specialty peculiar to that unit for a period of 14 weeks. Those who enlist in medical units receive their medical specialty training at our Medical Training Center, Fort Sam Houston, Texas. Two weeks leave rounds out their six months of active duty for training, and they return to their homes to rejoin their parent unit. These men must participate satisfactorily with their unit for seven and one-half years to complete their military obligation of eight years.

The Act also provides for a more effective screening of the Ready Reserve, which includes the elimination of, or placing in the Stand-By Reserve or Retired Reserve if qualified, those who no longer have a military obligation and who do not desire to participate actively. Also, those who are classified as critical specialists, provided they are in excess of the needs of the armed forces, and who so desire, may be transferred to the Stand-By Reserve.

One of the problems that will arise again, if we mobilize, is the problem of dual-vulnerability; "Which agency is to have preference in utilizing the service or professional skill of a Reserve officer who may be a professor in a teaching institution, a director or staff member in a civilian hospital, or a director or staff member in another governmental agency." I do not have the answer, but this matter is currently being considered by the Department of Defense and the Office of Defense Mobilization.

As you know, there is a critical shortage of medical and dental officers in our Reserve program. Of the table of organization and equipment (T/O&E) strength only 42 per cent of medical officers are on the rolls. To improve this situation, we have instituted an "early commissioning program" for students enrolled in medical and dental schools. These stu-

dents now may be commissioned as 2nd lieutenants, MSC-USAR, while attending school. Those who so desire may join a unit and participate in the two-hour weekly drills. Those who do not desire to join a unit may join what is known as a USAR Control Group and go to a summer camp for 30 days during their summer school vacations. Those between their junior and senior years, who are selected, may participate in our Clinical Clerkship Program of six weeks' duration at one of our training hospitals. From there, if selected, they may participate in our senior medical or dental student program where they are paid full pay and allowances while completing their senior year at school. Upon graduation from school, they are commissioned as first lieutenants. Upon completion of internship, which may or may not be in an Army hospital, they are promoted to captains and enter on active duty with one year pay back time in addition to any other service obligation.

We are trying to build up our Reserve to a state of readiness that will permit it to accomplish its assigned mission when called upon in a national emergency. Our efforts to strengthen the Reserve have been aided materially by the substantial support you have given in the past. Your recognition that a strong Reserve is vital to our national security, and the continued support of your organization, together with other state and national associations will go far toward ensuring the success of the Medical Reserve Program.

Family care is an essential factor in the morale of troops and, therefore, basic to the accomplishment of the Army mission. Medical officers, being both doctors and soldiers, will stretch their capabilities and endurance to the limit before they will deny service to a dependent requiring medical care. Provision of medical care to families is being tightened up throughout the Army, but it cannot be eliminated nor can it be substantially reduced until other adequate provision is made for such care. The Army Medical Service must constantly be prepared to support combat. If during peacetime the care of families becomes our major workload, it cannot help but de-emphasize our preparedness efforts. It is my hope that the legislation under consideration (see the Executive Secretary's letter, *J.M.A.G.* 45:383-384 Sept. 1956) by the Congress will assure good medical care of Army families and provide for an effective distribution of this workload between military and civilian resources.

I feel certain you have not only read much about this legislation in the journals but have discussed it with your colleagues. Obviously, a detailed recital here of its many provisions would not only be too time consuming but would be unprofitable. As a

consequence, I propose to limit my remarks and point out the principal provisions and general objectives of this legislation.

In order to bring about an improved program of dependent medical care and to define by statute the legal entitlement to medical care on a uniform basis, the legislation sets forth the dependents entitled to such care, the type of care to which they are entitled and, insofar as practicable, the method by which they will receive medical care.

Under the proposed law, families of military personnel are entitled to medical care in facilities under the jurisdiction of the uniformed services subject to the availability of space and facilities and the capability of the medical staff, and also to hospital care in civilian hospitals with the government paying part of the cost.

This legislation does not contemplate any new expansion of medical facilities for the uniformed services. It recognizes the fact that an estimated 40 per cent of the dependents of our active duty personnel do not now receive medical care from military hospitals. This has created a serious morale problem and undoubtedly contributed greatly to the decision on the part of many individuals not to make the service a career. It recognizes also the fact that medical care in service facilities in the past was based upon the chance of assignment, so that individuals who were fortunate enough to be in an area where a military hospital existed received medical care at Government expense, while others in areas where there were no military hospitals were not able to receive this care. This legislation authorizes the Secretary of Defense to contract for medical care in civilian facilities for servicemen's families. The minimum benefits to be provided are fixed, and the sole charge to the dependent would be the first \$25 of hospital expenses.

Wives and children of active duty personnel on duty at military posts where military medical facilities are available may receive care either in military or civilian facilities under regulations which the Secretary of Defense may prescribe. It is my hope that in many of our overcrowded military hospitals in this country, the civilian profession can assume part of this load under the provisions of this legislation, especially in obstetrics and pediatrics.

I am confident that this legislation will be of benefit not only to the servicemen and their dependents but to civilian and military physicians. It is too much to hope that it will operate smoothly from the start; undoubtedly some bugs will develop initially, but a determined effort on the part of civilian physicians and associations such as yours in conjunction with the Department of Defense will result in a successful

joint venture in which the medical profession can take pride.

For the past several years the Armed Forces have had to rely on the "Doctor Draft" to provide the medical care required by our armed forces. During this time the Department of Defense has been actively exploring every avenue of approach to eliminate the need for this law. I am hopeful that the career incentive legislation together with favorable results from the procurement programs we have established will provide at least two-thirds of our requirements and satisfy, quality wise, our need for experienced physicians and specialists; this group together with those brought in under a modification of the regular draft will provide an acceptable medical service. I believe it is probable that a modification of the regular draft will be necessary to bring doctors into the service, since the regular draft policy is not to call men over 26 years of age. By the time a student graduates from medical school and completes his internship he will be over 26 and exempt under present policy. I would like to point out that this is not altogether discriminatory against doctors, since deferment for medical education and internship would normally carry beyond age 26, and if some modification were not made, doctors would not be drafted, while the rest of the male population continued to be called.

Sometime ago it became obvious to all three military departments that radical action must be taken to increase attractiveness of the medical officer career. The Secretary of Defense appointed a "Task Force" from all three services to make specific findings and recommendations to attract career medical and dental officers. I will briefly mention what has been accomplished in putting the recommendations of the Task Force into effect.

Direct increase in pay requires Congressional action. The Congress, as you know, has passed the so-called "Career Incentive Bill for Medical and Dental Officers" providing substantial increases in the "special pay". This legislation gives medical and dental officers \$50 a month "special pay" increases after completion of two, six, and 10 years' service. This amounts to a maximum of \$250 a month instead of the \$100 formerly provided. Increased pay through promotion in rank is, to a considerable degree, within the authority of the departments. We were able to secure approval for increased promotions in the Army Medical and Dental Corps. These promotions have been implemented and, for example, over 1600 first lieutenants were appointed to captain. From now on the only lieutenants in the Medical Corps will be interns. I am sure this will result in improvement both in retention and in recruitment of volunteers.

Medical Care Expenditures

THE ACTUAL NUMBER of dollars spent for every category of personal consumption expenditures was greater in 1955 than in 1952. Total personal consumption expenditures—which exclude public expenditures—increased \$35,643 million during the years 1952-1955 inclusive, and personal consumption expenditures for medical care increased by \$1,875 million. The year 1955 marked the first time that the number of dollars spent for hospital services, \$3,130 million, was greater than for physicians' services, \$3,070 million. Thus in 1955 the proportion of total personal consumption expenditures going for hospital services, 1.232%, was greater than the proportion going for physicians' services, 1.209%. The consumer spent more dollars, \$3,182 million, on personal care (toilet articles, barber and beauty shops) than on either hospitals or physicians' services. He also elected to spend 5.1% of the total on recreation as compared with 4.4% on all medical care items.

Considering just the total spent for medical care—\$11,272 million—as 100.0 cents, that portion of the medical care dollar going for physicians' services decreased by 1.3 cents, dropping from 28.5 cents in 1952 to 27.2 cents in 1955. During the same period, personal consumption expenditures for hospital services increased by 2.3 cents, rising from 25.5 cents to 27.8 cents.

The Bureau of Labor Statistics' Consumer Price Index for all commodities and services, as well as component indexes for groups of commodities (food, apparel) and services (rent, personal care, medical care) is now based on the average for the years 1947-1949. This period, it is generally conceded, was one of post-war inflation. Indexes based on the earlier and more stable period of 1935-1939 are also prepared by the U. S. Bureau of Labor Statistics, but these "old base" indexes are not widely circulated;

Taken from "Medical Care Expenditures and Prices, 1955," by Frank G. Dickinson, Ph.D., Director of the A.M.A. Bureau of Medical Economic Research.

the monthly press releases feature the "new base" indexes. The publicized new base index for all commodities and services was 114.8 for 1954 and 114.5 for 1955 while the indexes for medical care and drugs were 125.2 and 128.0 respectively; these comparisons given the impression that medical care prices are sky-rocketing. The old base Consumer Price Index for 1954 and 1955 was 191.9 and 191.4, while the indexes for medical care and drugs were only 173.9 and 177.8 respectively. These little-publicized price indexes, which are just as authoritative as the widely publicized indexes, convey the information that medical care prices have risen moderately in relation to the ascending scale for all commodities and services since 1935-1939.

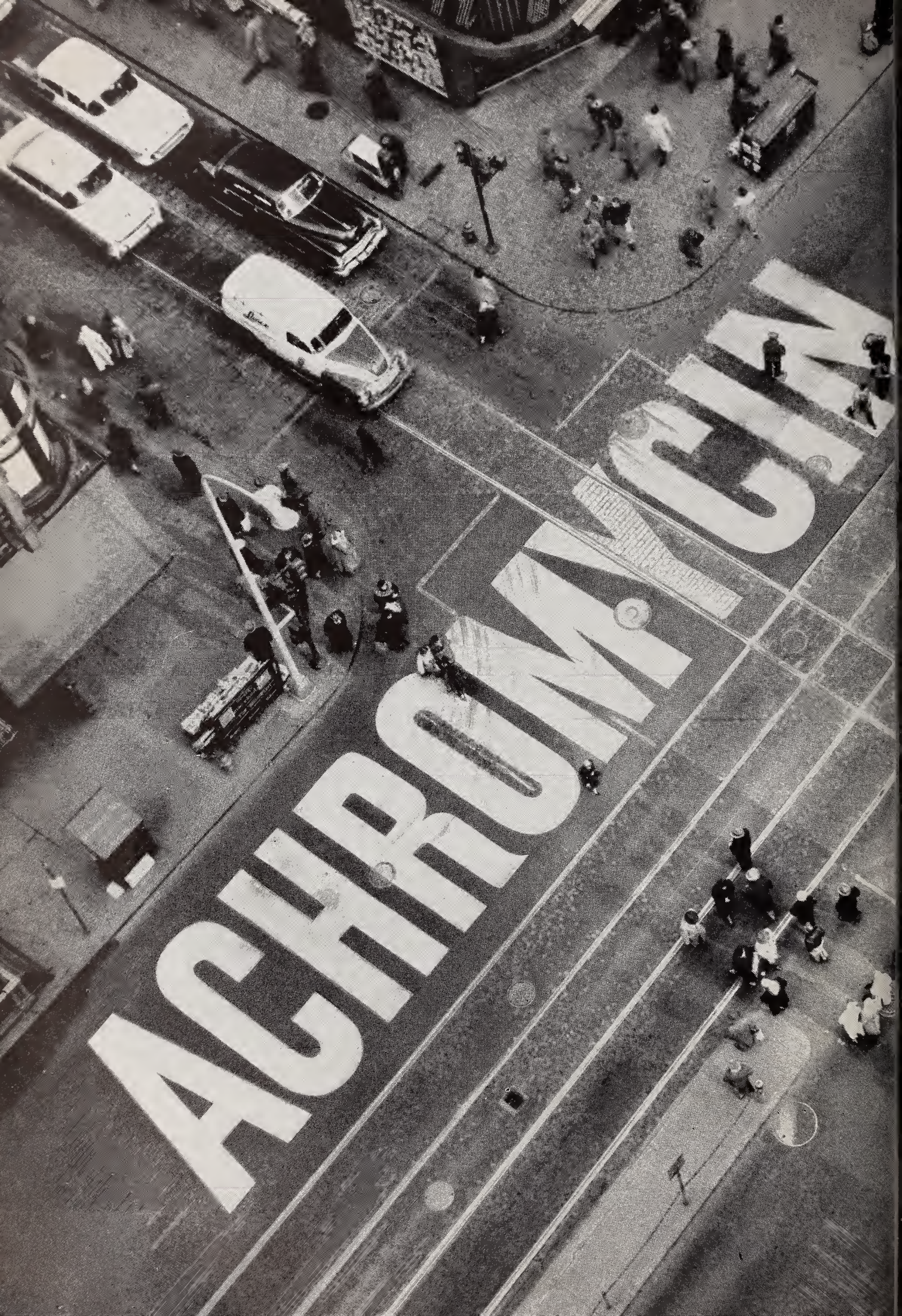
Actually, the price rise of most commodities occurred *before* or *during* the years 1947-1949, whereas the rise in the price of most services occurred *after* 1949. When the total Consumer Price Index is broken into its most general components—Commodities and Services (excluding rent)—the old base indexes for commodities, 207.7 for 1954 and 204.6 for 1955, were *higher* than those for services, 175.8 for 1954 and 179.9 for 1955. But the new base indexes for commodities were *lower*, 109.8 for 1954 and 108.1 for 1955, than those for services, 128.4 for 1954 and 131.4 for 1955. *This contrast is a general reflection of the point that services (including physicians') now seem more expensive than commodities simply because services are later movers in the inflationary spiral; they are still lagging.* For example, the 1955 index for physicians' services, 123.3, was higher than the new base Consumer Price Index of 114.5—a difference due to the earlier and sharper rise in the price of commodities. The index for hospital room rates reflects the full impact of inflation on both the goods and the services hospitals purchase; both the old base and the new base indexes for hospital rates were very much higher than the entire Consumer Price Index.

Military Problems (cont'd)

I hope that my brief remarks on the subjects I have discussed today have served to give you a clearer picture of some of the more important problems confronting the armed forces medical services and our efforts in reaching a solution. There are other problems in addition to these, all of which are of importance and which the Medical Services must solve. The ability of the Army Medical Service to accomplish its mission is not dependent on those dedicated individuals in the service alone. The appreciation and understanding of our problems by the civilian medical profession and the interest of your

association are equally important. We in the armed forces realize that without the support and encouragement of the civilian medical profession ours would be a difficult if not impossible task. The splendid spirit of co-operation which exists throughout the medical profession as evidenced by this meeting, and your interest in the problems of the services is both reassuring and encouraging to me. I know that with your continued support the armed forces medical services can face the challenge of the future with confidence.

Office of the Surgeon General, U. S. Army





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¹Posner, A. C., *et al.*; Further Observations on the Use of Tetracycline Hydrochloride in Prophylaxis and Treatment of Obstetric Infections, *Antibiotics Annual* 1954-55, pp. 594-598.



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Back-Half Headache

WILLIAM R. CHAMBERS, M.D., Atlanta, Ga.

THE TERM, "back-half headache", is not meant to designate an entity. It is intended, rather, to describe and encompass a whole class of headaches which have their origin from, and their greatest intensity in, the occipital region and the back of the neck. This is not an uncommon group of headaches. It is probable that every medical practitioner will see many of them in a year's time. The intensity may be very great, requiring narcotics for relief.

From time to time, various etiologies have been popularly assigned to headaches in this position; cervical arthritis, rheumatic induration, occipito-cervical myositis, and fibromyositis, to mention a few. Each such concept has gradually lost much of its charm. Today, it is popular to think of all such headaches at the back of the head, first and foremost, as tension headaches. That he who leans to such a diagnosis may so often be right, in these days of universal stress, may tempt the medical profession into a glib attitude. Confident of the support of probability, we lie in danger of failing to apply the same imagination and sincerity of investigation to this disease as we might to a diagnosis in some other part of the body.

The purpose of this paper is to act as a reminder that the easy and offhand consignment of cases with pain in the back of the head to a popular diagnosis of anxiety reaction (or tension headache) may lead to danger for the patient, and humiliation for the



Figure 2

Case 1. Widened foramen magnum.

physician. It is not my purpose to belabor you with illustrative cases, the solution of which should be obvious. Subarachnoid hemorrhage, with its cataclysmic headache, stiff neck, and bloody spinal fluid, I am sure would be recognized by all of you. It is my intent, rather, to present examples of headaches caused by serious lesions in which the solution was not obvious, and in which the diagnosis of tension headache was considered or actually made.

Case 1, M.B.

A 37-year-old white female complained of severe headache in the back of the head and the neck of six weeks' duration. In addition, there was stiffness of the neck and a slight tendency to become confused in conversation, which she attributed to the fact that her pain was so great. Twelve years before this present attack, she had had a similar one which had kept her bedfast for six months. In the interim, she had continued to have severe headaches of short duration, one or two days, at irregular widely spaced intervals. She had also suffered from what sounded like a "globus hystericus", a ball in her throat that made swallowing difficult.

On this occasion, her physician made skull x-rays and did a spinal tap. He reported an enlargement of the sella and a spinal fluid pressure of 390 millimeters of water. On her arrival for examination, we were dis-

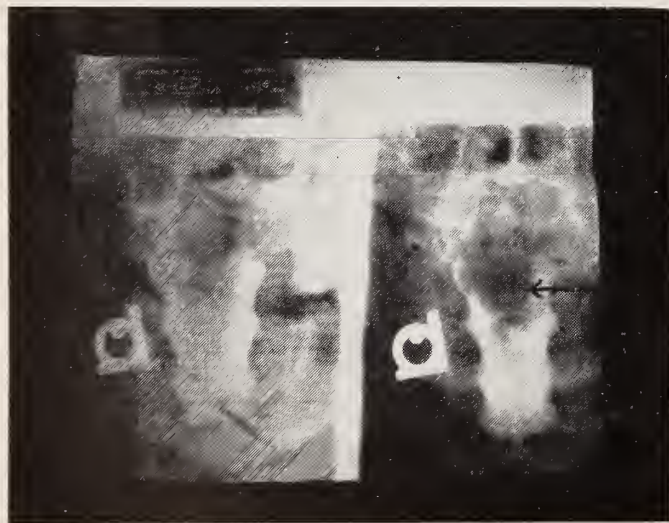


Figure 1

Case 1, M. B. Dermoid of upper cervical canal and post fossa. Occipital headache. Negative neurology.

Presented at the 106th Annual Session of the Medical Association of Georgia, May 13-16, 1956, Atlanta, Ga.

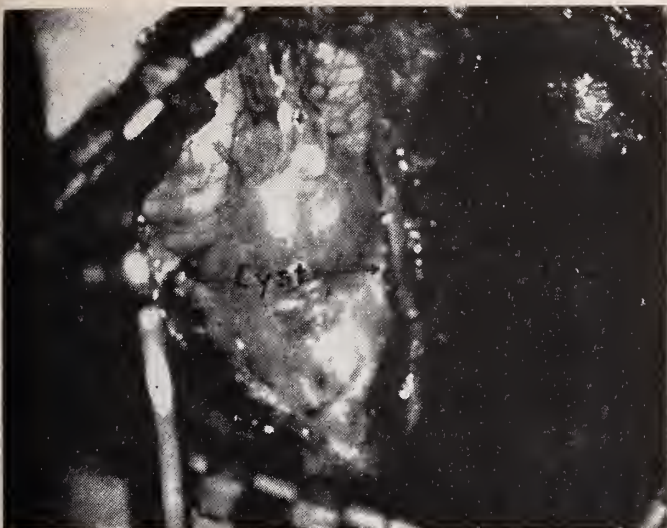


Figure 3

Case 1. Dermoid cyst at operation.

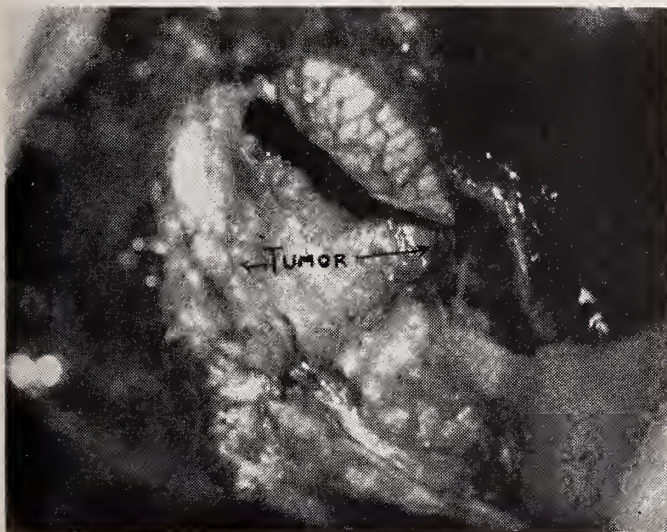


Figure 4

Case 1. Dermoid extending into left cerebellum.

appointed to find that her spinal fluid pressure, now taken for the second time, was only 90 mm. of water. Furthermore, the findings in the sella were put to some question after careful measurement by the x-ray department. The neurological exam was completely negative. In anticipation of subsequent discoveries, it should be noted that there was no nystagmus, no past pointing, no dysdiadokokinesis. There was no papilledema, the cranial nerves were intact, the deep tendon reflexes were equal and physiological, and there were no abnormal reflexes.

In spite of a negative neurological, a myelogram was done, and at the extreme upper end of the spinal canal a mass was encountered almost completely obstructing the passage. (Figure 1). Then, in retrospect, the plain films were reviewed, and a definite widening of the foramen magnum and first three laminae arches seen. (Figure 2)

Operation revealed a huge, extramedullary cyst of the foramen magnum (Figure 3) which led upward and disappeared into the left cerebellar hemisphere. Here there was a small nodule of tumor, easily removed. The cyst, which practically replaced one cerebellar hemisphere, was filled with a large mass of greasy, amorphous substance (Figure 4) which could be rolled out like a tennis ball.

The lady enjoyed breakfast next morning, and has continued rapidly to improve, headache free.

This case spotlights two important points. First, slow growing, long standing benign tumors may be associated with no (or almost no) neurologic signs over many, many years. Second, clinical neurologic examination and testing now available is often insufficiently accurate to detect such tumors, and the only way to reveal them early is to employ all the armamentarium of neurological diagnosis, the myelogram, the angiogram, and air study.

A second case illustrates how failing to use the diagnostic tools at hand may lead to missing a dangerous neurological condition.

Case 2, R.R.

A 30-year-old white female complained principally of back-half headache radiating up into the vertex and down into the neck. About one year previous to examination she consulted a doctor because she had become nervous and would cry very easily. About six months before, she began having severe, continuous headaches which interfered with her sleep and her daily work. She had also developed a choking on her food, occasionally, very suspicious of "globus hystericus".

She was referred to an excellent medical center, where it was noted that the base of the skull was very flat and a diagnosis of platybasia (Figure 5) and anxiety reaction



Figure 5

Case 2, R. R. Platybasia, occipital headache.

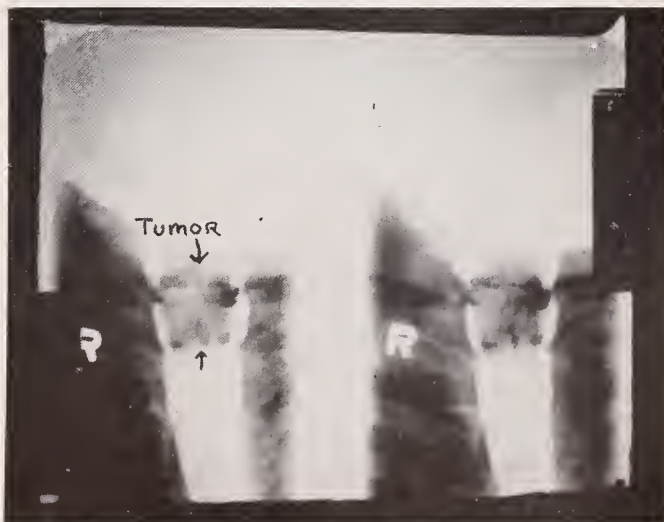


Figure 6

Case 2. Myelogram showing tumor, foramen magnum.

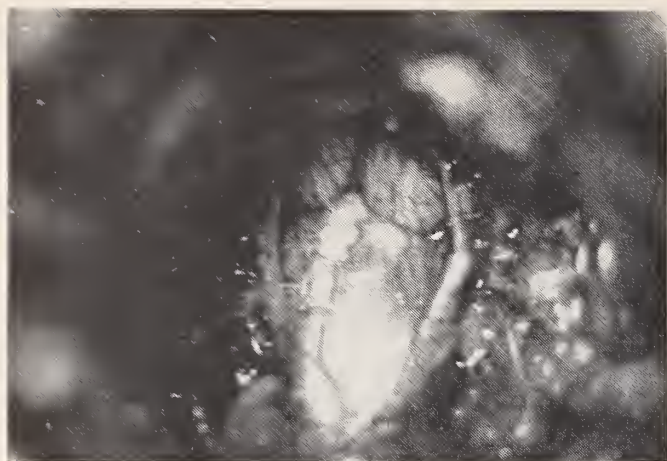


Figure 7

Case 2. Hydromyelia of cervical cord.

was made. In spite of appropriate treatment for tension headache, she grew worse. Her doctor advised further study.

Examination showed a patient with an extremely short, wide neck. She had a strange way of talking through her teeth. Her grandmother and one uncle had both died of brain tumors, and she was inclined to be very apprehensive. Except for a slight flattening of the nasolabial fold on the right, no neurological changes could be found.

In 1940, Gustafson and Oldberg¹ in a large series of cases, pointed out the connection between platybasia and hydromyelia of the spinal cord. They were able to quote a number of authors who previously had noted the same association. A myelogram was therefore done, and a large tumor was demonstrated in the upper cervical (Figure 6). List² and Ray³ have confirmed that platybasia, allowed to continue, will frequently result in serious neurologic disease. A laminectomy was undertaken and a tremendous bulging of the spinal cord was seen. (Figure 7) Here was tension headache literally, so much tension that it seemed ready to burst the cord. A large hydromyelia, a cavitation of the cord secondary to the platybasia, was evacuated and drained. The platybasia was decompressed, and the patient is practically headache free.

In 1954, Love, Thelen, and Dodge⁴ reported 74 cases of tumor of the foramen magnum discovered at the Mayo Clinic. Of these, 15 showed no motor or sensory symptoms, but occipital pain as an initial complaint was common. They warned that "these lesions are likely to go unrecognized until serious and often tragic sequelae have occurred."

Occasionally, when all diagnostic methods fail to show the lesion, the neurosurgeon will have to risk operation on the basis of minimal findings, rather than risk failure to eradicate one of these lesions.

Case 3, M.C.

A 27-year-old white female complained of a severe right sided occipital headache of three years' duration. The pain had frequently required narcotics. Many apparently nervous symptoms had ensued. A presumably

hysterical paralysis from the waist down, for several weeks, occurred during the course of her illness. Many forms of conservative therapy had been tried. Halter traction only aggravated her pain, and when a strong pull was exerted, caused her to black out. She had already been operated upon twice when first seen. Neither exploration of cerebello-pontine angle nor rhizotomy had benefited her. On examination, she showed only one neurological sign; her tongue deviated to the right. Knowing her surgeon was a very skillful one who operated through very tiny openings, I deduced that he had been able to do both operations without exposing the neighborhood of the hypoglossal nerve which lay between his two operative sites. On exploring this area, a small angioma was found. A tiny artery seemed to course into it. One silver clip was placed on this artery, and the angioma collapsed. The patient has now remained headache free for two years.

Cushing and Bailey⁵ were the first to describe vascular malformations at the foramen magnum, in 1928. I have now encountered this condition four times, and in every instance occipital headache was the initial symptom.



Figure 8

Case 4. Dislocation of C₁ on C₂, displaced odontoid.

Proceeding downward from the skull to the neck, many authors have shown the relationship of cervical lesions to occipital headache. Grinker⁶, Hadden⁷, Pollock⁸, Horton and Macy⁹, Nielsen¹⁰, and Josey and Murphy¹¹ have attended to such a relationship. Occasionally, however, a serious neck injury will be overlooked and interpreted as a tension headache, when a simple x-ray could have revealed the diagnosis.

Case 4, E.P.

A 40-year-old white male had a fall, striking his head, nine years before examination. Soon after the fall, he began to have severe pain beginning in the back of his neck and radiating up over the occiput and forward into the left eye. When the pain began, he held his head stiffly, well over to one side, with the chin pointed up. He had had psychiatric care, also other excellent medical attention, and numerous x-rays. But an open-mouth view of the upper cervical spine had not been taken. This view (Figure 8) shows a partial dislocation of C₁ and C₂ and a displacement the odontoid.

Such injuries in the neighborhood of the atlanto-occipital junction are probably more common than is generally known. Colson¹², Coutts¹³, Donaldson¹⁴, Farthing¹⁵, Hess¹⁶, Jostes¹⁷, Kahn¹⁸, Sullivan¹⁹, Walton²⁰, and Wilson²¹ have all called attention to such injuries. They may result simply in severe intractable headache, as in this case, or they may gradually develop multiple sclerosis-like symptoms.

Congenital dermal sinus is a term applied to any depression or tract extending inward from the skin surface. The well known pilonidal sinuses are incomplete dermal sinuses in the sacral region that go no deeper than the sacral fascia. Other sinuses, however, may extend all the way in, and because of their persistent communication with the skin surface, may serve as constant potential ports of entry for infection into the central nervous system. Ingraham and Matson²², Morse²³, Mount²⁴, Sachs²⁵, List²⁶, and many others have reported these anomalous defects. In, or close to the midline, most commonly in the occipital region, may be a tiny dimple or sinus tract.

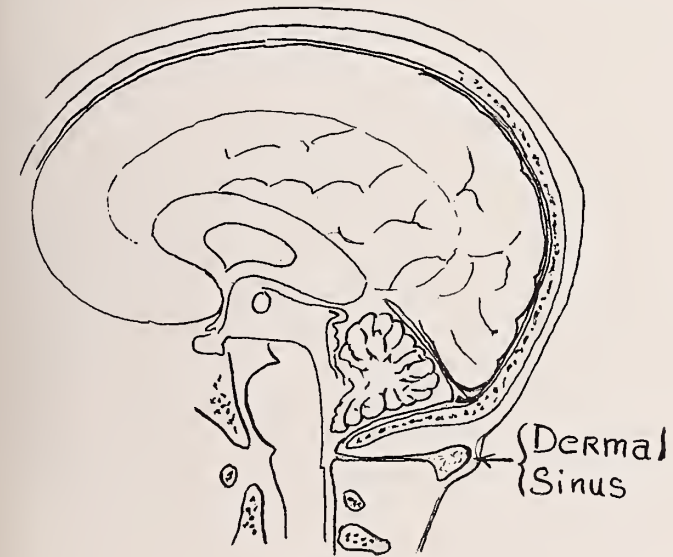


Figure 9

In many patients there is, in addition, thickening of the scalp in this region, or an actually palpable, small subcutaneous mass. Drainage from the mouth of the sinus may first call attention to it. (Figure 9) The results of treatment of these patients is poor, according to Ingraham²², when diagnosis was made only after infection had set in. If there has been infection, then an intense meningeal reaction usually results which may obstruct the normal circulation of the spinal fluid, with hydrocephalus and death.

Case 5, L.C.

A 34-year-old white male complained of pain in the back of the neck, radiating forward into both eyes. Two years previous to examination he had a siege of strep throat, after which his headache began. He had his tonsils out, but the headache was only intensified. Almost from the onset, there was marked stiff neck. The headache became completely disabling in spite of

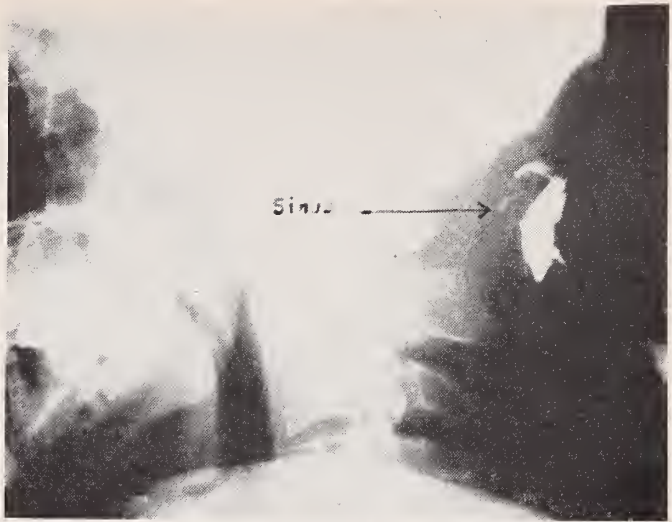


Figure 10
Case 5. Dermal sinus, injected.

various forms of physical therapy. An E.E.G., a myelogram, and a pneumoencephalogram were done elsewhere, without a diagnosis being made. He then was referred to a psychiatrist and submitted to two series of shock treatments without benefit. His family physician discovered a "lump" in the back of the neck and took it out. The area of the incision continued to drain a clear fluid for three months.

Injection of the incisional area with pantopaque revealed a sinus pointing inward toward the spinal cord. (Figure 10) Exploration of the atlanto-occipital area demonstrated a sinus tract leading into the arachnoid at the atlanto-occipital junction. There was evidence of wide-spread low-grade infection and arachnoiditis in the posterior fossa. A biopsy of the arachnoid was reported as showing chronic inflammation.

The arachnoiditis could not be controlled, and this patient later died of acute hydrocephalus due to obstruction in the region of the fourth ventricle. Whether this man's life could have been saved by earlier discovery of the true nature of his illness, I am not sure. Sachs and Horrax²⁵, however, have this to say: "It is not generally appreciated that sinuses of this kind, instead of being harmless fluid tracts, may communicate directly with the subdural or subarachnoid space. Knowledge of this fact, in the presence of a pilonidal sinus, should lead to earlier surgery."

Occipital headaches due to ruptured intervertebral disc of the neck may be difficult to diagnose. Raney and Raney²⁷, in describing this kind of headache, remind us, "The neurologic examination may disclose no detectable motor, sensory, or reflex changes, just as early stages of lesions of the lumbar discs may produce no such disturbances." When no signs diagnostic of ruptured disc are present, the examiner may be tempted to think of the patient in terms of anxiety reaction or of cervical arthritis. Oppenheimer, as early as 1937, pointed out, "Primary lesions of the intervertebral disc are a common cause of exostotic formations known as hypertrophic or deforming spondylitis. Bony proliferations, arthritic lipping, are betraying evidence of nature's attempt to heal the pathologic discs by physiologic immobilization".

Only careful watching over a considerable period of time, or a myelogram, or both, will reveal the presence of a disc as the source of the pain.

Case 6, L.E.

A 44-year-old white female complained of severe headaches in the occiput, radiating to the vertex and into the left eye. There was also pain in the neck spreading up to the occiput and down into the left shoulder. There was stiffness of the neck and limitation of motion of the left arm due to pain. All this had been present for 10½ months following an automobile collision. Meanwhile she had had good conservative therapy with only temporary relief.

Examination showed exquisite tenderness over the neck at the level of C₅-C₆. At first there were none of the characteristic signs of a compression of the C₆ nerve. There was no biceps weakness, no diminution of the biceps reflex. There was no sensory change over the dermatome of C₆. The absence of such signs led one to doubt seriously the validity of her complaints. A myelogram, however, showed definite evidence of a ruptured disc at C₅-6. (Figure 11) Operative treatment of her disc has rendered her headache free.

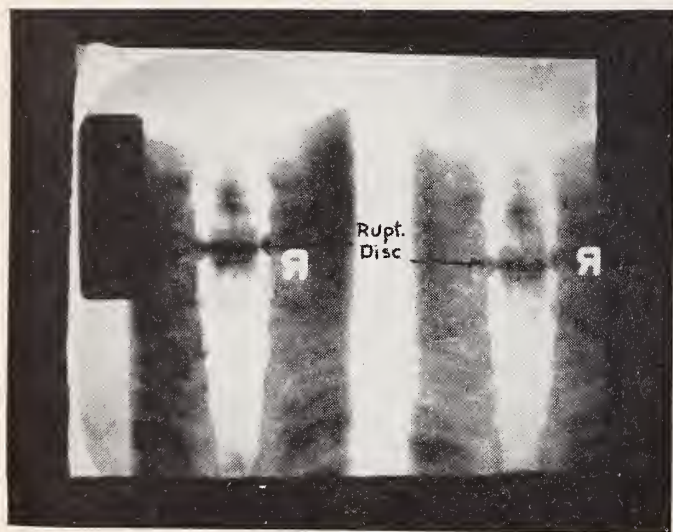


Figure 11

Case 6. Myelogram showing cervical disc.

This patient's case is not unique. I have seen many ruptured cervical discs, whose principal complaint was headache, and have operated on seven. Of these seven, five have given excellent results.

Comment

Headache remains a big problem. In one series, it accounted for 24 per cent of more than 15,000 absences among factory employees²⁷. Some of the headaches, as in this series, cannot be taken lightly, merely because the objective findings are few. As List²⁶ says, "In slowly growing neoplasms the degree of objective motor and sensory impairment may be amazingly slight in comparison to the magnitude of the anatomical damage."

Routinely branding those headaches that occur at the back of the head as tension headaches, may do harm. It may discourage other clinicians from employing available diagnostic tests. The patient may become depressed and tend to accept his lot as a headache cripple, rather than seek further help. The

six cases related here are only a few of those that could be presented to illustrate the wisdom of going all the way in the diagnosis of severe intractable headache at the back of the head. Delay, as in subjecting these patients to a period of psychotherapy, may be fatal in some cases.

Summary

1. Six cases are presented of headache centering in the back of the head, caused by serious organic disease.

2. In all six cases there had been a serious element of doubt as to whether the patient had anything organic.

3. Some of these cases had actually been labelled as anxiety reaction, or tension headache, and others had been detoured through periods of strenuous psychiatric therapy which delayed their final solution.

4. It is suggested that the same determined thoroughness of diagnosis should be applied to a patient with back-half headache as the gastroenterologist employs on the stomach or the cardiologist on the heart, before that patient is relegated to the ranks of the neurotic.

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Antibiotics in Pulmonary Disease

INDISCRIMINATE USE of antibiotics is a topic familiar to the physician. It is not possible to quantitate accurately the usage of antibiotics, yet the fact that over one third of the nation's entire drug bill is devoted to the agents probably indicates misuse to some extent. It seems quite likely that a significant part of this widespread usage is related to treatment of infections of the respiratory tract and lungs. Doctor McClement's six guides to antibiotic use in pulmonary disease (see page 455) are sound and apply basic principles which would curtail, in large part, the indiscriminate use of these agents. Several factors which still complicate the intelligent use of antibiotics in pulmonary infections seem worthy of additional comment.

The contrast between powerful "Twentieth Century" antibiotics and the inadequate, often protracted "Nineteenth Century" diagnostic methods in microbiology became apparent over a decade ago in the management of bacterial infections of the respiratory tract. In the absence of accurate clinical diagnosis, the physician quickly accepted the necessity of exact etiologic diagnosis to help avoid incorrect management of the suppurative, rapidly destroying pneumonias. Nonetheless, practical rapid methods for specific etiologic diagnoses have not been forthcoming. Almost total reliance still must be placed upon the stained smear of sputum and the Quellung reaction with subsequent confirmation by culture on artificial media. Although these methods are extremely valuable, the need for additional rapid diagnostic procedures is all too evident.

The lack of a definite diagnosis often leaves the physician with a complex problem of protecting his patient during the early phases of a severe illness. This dilemma most often leads to the concurrent use of two or more antibiotics through the desire to guard the patient against all eventualities. Granting that there is justification perhaps in temporary use of antibiotic combinations, such therapy cannot be regarded as a substitute for etiologic diagnosis and specific therapy. There are, however, several situations in pulmonary infections where the use of combinations of antibiotics may be justified.

In the treatment of mixed infections, i.e. lung abscess, bronchiectasis, etc., wherein only a portion of the bacterial population is sensitive to a single agent, the use of combined therapy would seem indicated. Experience with penicillin in lung abscess,

however, indicates that a favorable result frequently may be obtained by destruction of the most virulent organism present. Furthermore, a single "broad spectrum" drug may encompass the entire spectrum present in the lesion. Nevertheless, combination of antibiotics may be justified in the face of a mixed bacterial flora especially when more than one potential pathogen is encountered.

To delay the emergence of resistant strains forms an important basis for combined therapy. This principle, applied mainly in chronic infections such as tuberculosis, is exceedingly important in situations in which streptomycin is used. The rapid development of total resistance of certain bacteria, notably the Gram negative organisms, to streptomycin is well established. The addition of a second agent effective against the particular infecting organism may delay or prevent such resistance.

Achievement of a synergistic effect is usually considered as an indication for combined therapy. The few situations in which this effect has been documented by adequate clinical evidence, however, do not apply primarily to pulmonary infections.

Another major contribution to the large drug bill comes from the use of antimicrobials in prophylaxis against infection. The greatest enthusiasm for prophylaxis is applied to diseases of the chest in which anatomical defects, either acquired or congenital, play a very important role in the acquisition and maintenance of infection. Full restitution of the normal host-defense mechanisms rarely can be accomplished in these patients. Through alleviation of obstruction and irritation with subsequent improvement in endobronchial drainage, partial restoration of these normal mechanisms often results in decrease in the frequency and severity of infections without chemoprophylaxis. Until further documentation is obtained in support of chemoprophylaxis, the major efforts in the management of these problems should be directed at improvement of existing defense mechanisms.

Fortunately, the antibiotics in common use in the treatment of pulmonary infections are drugs with relatively low toxicity when properly used, but even so, there are serious potential hazards. It has become increasingly apparent that the use of even the most innocuous antibiotic may have serious repercussions in terms of drug sensitization, toxic effects on certain tissues and the production of antibiotic-resistant strains. Although the intelligent use of these agents will not eliminate all of their disadvantages, the risk



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to the patient with pulmonary disease can be materially reduced by adherence to the guides to therapy outlined elsewhere in this issue.

Charles Le Maistre, M.D.

Hospital Auxiliaries

WITH THIS MONTH'S COVER, the *Journal of the Medical Association of Georgia* salutes the Hospital Auxiliary—an organization devoted to service to the patient and the personnel of the hospital.

Practically every hospital in Georgia numbers among its complement, hard working volunteers who ask for nothing more than the chance to serve. One such group is the Hospital Auxiliary, an organization composed of lay women, some of whom are doctors' wives. Each auxiliary carries on a varied program of activities including such services as letter writing for the patients; mending hospital and patient apparel and linens; staffing gift shops and rolling carts (with proceeds going to worthy causes); reading, shopping, and telephoning for the patients; assisting medical personnel in the wards and clinics; planning parties for children; donating furniture, television sets and supplies for wards, rooms, nurseries, etc.; and many other patient services too numerous to name.

The case of a 19-year-old college student serves as a typical example of one auxiliary's activities. The boy sustained back and neck injuries which required immobilization and long convalescence. Auxiliary members not only helped the boy with his studies,



A traveling hospital shop.

telephone calls, shopping, etc., but aided his widowed mother, from another town, to find living quarters and work near the hospital while her son was a patient.

In addition to services to the patient, many auxiliaries have been of immense help to nursing schools in such ways as establishing scholarships for deserving students, underwriting and chaperoning social functions, conducting tours, and inviting students into their homes—in short, “making a home away from home” for the student nurses.

The humanity of these workers is well expressed in the official prayer of the American Hospital Auxiliary:

“Almighty God and Heavenly Father of Mankind, bless us we pray Thee, our endeavors in this hospital in which we strive to bring comfort and hope to all who are in distress of mind or body.

“Guide us so that we may use the privilege given us to help the aged, the ill and the very young—with generosity, with discretion and with gentleness.

“Give us the strength to labor diligently, the courage to think and speak with clarity and conviction but without prejudice or pride.

“Grant us we beseech Thee both wisdom and humility in directing our united efforts to do for others as Thou would have us do.” Amen.

Georgia's Medical Practice Act

FOR A NUMBER OF YEARS, various officers and committees of the Association and members of the State Board of Medical Examiners have repeatedly stated that the present law governing the practice of medicine in Georgia does not adequately control and regulate the practice of medicine either for the protection of the public or for the maintenance of high professional standards.



An auxiliary hospital shop.

An editorial in the *Journal* for August 1951 stated in part, "A study of our present laws reveals the astounding fact that our medical practice act contains practically no 'teeth' to curb illegal medical practices or even licensed but unscrupulous physicians to any extent."

To implement this long needed revision of the Medical Practice Act, the Executive Committee of Council appointed, on March 18, 1956, David Henry Poer and Enoch Callaway to represent the Association on a LIAISON COMMITTEE TO STUDY REVISION OF THE GEORGIA MEDICAL PRACTICE ACT. Subsequently, the State Board of Medical Examiners appointed Albert Deal and Grady N. Coker to represent the Board on the Liaison Committee.

This important committee met on June 13th and on July 25th to draw up proposed revisions. The MAG Council and the Board of Medical Examiners have since discussed these changes, and final details are being worked out by the Liaison Committee.

Basically, the proposed Amendment to the Medical Practice Act will consist of an expanded revocation section and the addition of an injunction clause, which many other Georgia examining boards already have.

You will be hearing more about the details of this important amendment which will be introduced at the 1957 session of the Georgia General Assembly, in January 1957. It is believed that this single bill will do more to raise the standards of medical practice in Georgia and to maintain high standards than any other single piece of legislation since the Act underwent major revision in 1913.

Every effort should be made to carry out the recommendations made by the Federation of State Medical Boards of the United States at the annual meeting in February. These are stated in "A Guide to the Essentials of a Modern Medical Practice Act," and the purpose of a medical practice act is outlined as follows:

"Recognizing that the practice of medicine is a PRIVILEGE granted by legislative authority and is not a NATURAL RIGHT of individuals, it is deemed necessary as a matter of policy in the interests of public health, safety and welfare to provide laws and provisions covering the granting of that privilege and its subsequent use, control and regulation to the end that the public shall be properly protected against unprofessional, improper, unauthorized and unqualified practice of medicine and from unprofessional conduct by persons licensed to practice medicine."

Your cooperation and support in the promotion and passage of this important amendment will be needed. We hope that you will do everything in your power to help us assure the public that high standards of medical practice will be maintained in Georgia.

The "Unknown" Diabetic

AT THE TURN OF THE CENTURY barely two per cent of our population lived beyond three score years. Acute illnesses, affecting in most instances the young, carried off the majority of population before they had reached their allotted "three score and 10." At the present time, however, almost 10 per cent of the population now living are over 60 years of age. This increased longevity, due for the most part to the triumph of medicine over acute illness, provides an increasing percentage of the population subject to ravages of chronic disease.

Diabetes is a disease which may be found in any age group, but with longevity the incidence of diabetes rises markedly. Almost seven per cent of the population over 70 years of age may be expected to suffer from some form of diabetes. The early diagnosis of this disease, coupled with our advanced knowledge of treatment and management of its complications, means that much may be done to spare the destructive forces which go on within the body when this disease is undetected and uncontrolled. The earlier the abnormality is discovered, the easier it is to control and the more normal and effective life the individual can have.

Each fall, throughout the United States the American Diabetes Association has encouraged and promoted a Diabetes Detection Week. This year, it is from the 11th through the 17th of November. During this time each person, in every community in the country, is encouraged to try and have some form of a test to determine whether or not diabetes may be present. Physicians in the state of Georgia are particularly requested to cooperate with their patients, not only in providing some form of a screening test, but also in advising and encouraging all patients to have such a test made. In the past year approximately two million persons were tested in doctors' offices or testing centers. The results of these tests varied considerably, but in general this testing confirmed our impression that approximately two per cent of the population of this country have diabetes in some form or other.

It is very easy for a physician to run an examination of a urine specimen for the detection of glycosuria. At the present time, three very simple and inexpensive methods may be used. The first is the old and reliable "Clini-test" tablet. A Clini-test tablet is added to 10 drops of water and five drops of urine. This causes a reaction which lasts for a few seconds and then within a matter of 10 seconds a color reaction is produced which indicates roughly the quantitative amount of sugar present in the urine specimen. During the past year "Tes-Tape" has been provided. This is a strip of paper impregnated with



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a substance which is color sensitive only to the presence of glucose. It is an enzyme reaction, and when a small strip of this paper is touched to a drop of urine, a color reaction will occur within one minute which also will give an approximate quantitative test for sugar. The last simple procedure is with "Clinistix." With this procedure a strip, somewhat like a paper match, is dipped in urine and a color reaction tells whether or not sugar is present. If the test is positive for sugar, it is then necessary to recheck with a Clini-test tablet to determine the quantitative amount. It should be stressed to your patients that fasting specimens of urine are of little value and, particularly in mild diabetes, may not have any sugar present. It is best to take a sample of urine within one to two hours after eating a meal in which considerable carbohydrate is ingested.

These tests for glycosuria are so simple and inexpensive that it should not be a burden for any physician concerned with the welfare of his patients to check the urine for the presence of sugar. The very little expense involved, if this service is offered to the patient free, will be well compensated in terms of goodwill and better public relations.

Any specimen of urine which is positive for sugar demands a recheck of this patient to determine whether or not a true diabetic condition exists, or

whether the glycosuria may be due to some other cause. The recheck should preferably be done in the form of a glucose tolerance test. This is the most positive way of determining whether or not a patient may be classed as a diabetic.

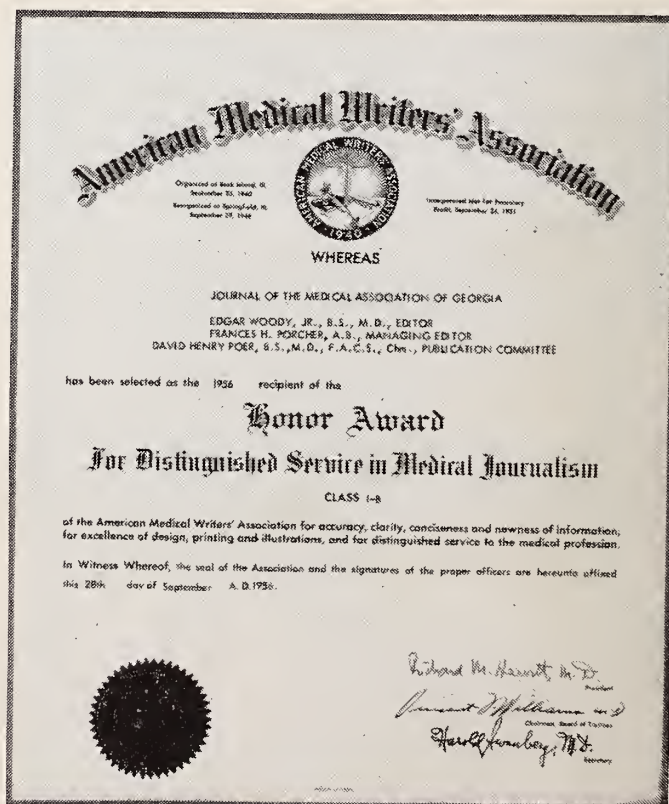
With two per cent of the general population of the United States being diabetic, we may expect, therefore, that 70,000 people in the state of Georgia now have or will in the future show clinical evidence of diabetes. It is very essential that each of our 2500 doctors accept the responsibility of finding and placing these individuals under treatment.

Within the past year, the Georgia Diabetes Association has been formed in affiliation with the American Diabetes Association. It is hoped that anyone interested in diabetes will become a member of the Georgia Diabetes Association. Its offices are in the headquarters of the Medical Association of Georgia in Atlanta. The objectives of the Georgia Diabetes Association are as those of the American Diabetes Association: First, to find as great a number possible of yet undiscovered diabetics. Second, to assist diabetics to lead normal lives. Third, to improve the treatment and management of diabetes. Fourth, to bring the newest information about the disease to all physicians. Fifth, to encourage and promote research in diabetes. The Georgia Diabetes Association stands ready to assist any physician in any problem related to the detection and management of this disease.

Christopher J. McLoughlin, M.D.

The Journal Wins Honor Award

ON SEPTEMBER 28, 1956, the *Journal of the Medical Association of Georgia* was presented the 1956 American Medical Writers' Association Honor Award for Distinguished Service in Medical Journalism, Class 1-B (general medical periodicals with less than 3,000 circulation). Edgar Woody, Jr., Editor of the *Journal*, and Miss Frances Porcher, Managing Editor, were in Chicago for the 13th Annual Meeting of the A.M.W.A., and Dr. Woody received the award at the annual banquet from the association's president, Richard M. Hewitt, of Rochester, Minn. The citation for the award reads as follows: "For accuracy, clarity, conciseness and newness of information: for excellence of design, printing and illustrations, and for distinguished service to the medical profession." Needless to say, the staff of the *Journal* is very proud of this honor bestowed by the American Medical Writers' Association, and it is hoped that our readers share some of the feelings of the judges.



Sterilization

JOHN A. DUNAWAY, Atlanta, Ga., Legal Counsel for the Medical Association of Georgia

IN 1937 THE General Assembly of Georgia enacted a sterilization law and created a State Board of Eugenics authorizing sterilization of persons in state institutions for the care of the mentally or physically defective, deficient, or diseased, and for the detention of those in a prison or penitentiary, correction school or reformatory, detention home, or camp if such persons would be likely, if released without sterilization, to procreate a child or children who would have a tendency to serious mental, physical, or nervous disease or deficiency. Although the law has been in effect for 19 years not one single case, so far as I can learn, has been carried to the appellate courts of this state, evidencing the fact that this law is either being administered very wisely or that it is not being used at all.

There is no statutory law in this state specifically authorizing or prohibiting sterilization of persons except those mentioned in the Eugenic Sterilization Law of 1937. There has been considerable inquiry from time to time from all over the State of Georgia by physicians for my opinion as to whether or not voluntary sterilization is legal in this state. My only answer has been that physicians must proceed cautiously in this area until some positive action of the legislature has been taken. The public policy of the State with reference to voluntary sterilization has not been indicated either by legislative enactment or court decision, and therefore it is my opinion that until the public policy of the State is definitely indicated, sterilization should not be performed unless the health of the female is involved or unless it is strongly indicated that such female is likely to procreate a child or children who would have a tendency to serious physical, mental, or nervous disease or deficiency, as in the case of those who are in the institutions of the State. It is my feeling that in the case of voluntary sterilization, the written consent of both the husband and the wife should be obtained where the health of the wife is involved and either the husband or the wife is the applicant for the operation.

It is to be noted that in the case of the male, sterilization is usually restricted to male sex offenders as a punishment for crime, and in some cases it is for avowedly eugenic reasons of criminals such as recidivists, that is, repeat offenders, habitual criminals,

and sexual perverts, so that insane or criminal stock will not be propagated.

I do not think many applications for the sterilization of the male will be voluntarily applied for, and great care and caution should be exercised by a physician before performing such an operation on a male. The physician ought to know the history of the individual including the health and mental condition of his parents if possible, something about his own life, and a great deal about the state of his health. Except in rare cases, voluntary sterilization, until some statutory law has been passed, should be limited to the female, as stated above for reasons of health only as applied to her.

It has been held in at least one state that it is against public policy for a male to have a sterilization operation performed upon himself in order that his wife may not have a child without serious danger to her life. The question of sterilization of the wife has been declared legal where it has been determined that such an operation is pathologically justified.

It has been stated by a federal court that a wife in full possession of her faculties is as much entitled to determine whether she shall submit herself to an operation as is the husband in respect to an operation upon himself.

In another case the court has held that the husband has no power to withhold from his wife the medical assistance which her case may require and that the consent of the wife and not that of the husband is necessary.

As a matter of good public relations, however, consent of both husband and wife should be first obtained in writing in which both state that they realize fully that the operation is necessary for the preservation of the wife's life. Failure to obtain the husband's authorization may indicate a lack of good faith either on the part of the wife or of the physician and subject the physician to a civil suit for damages. The husband's refusal should indicate to the physician that the operation must be demanded, and the physician ought to be supported in his position that it is demanded by at least one and preferably two other physicians whose statements he should have in writing in his file.

In this connection there is a reported case

Physicians Licensed by Reciprocity

THE FOLLOWING PHYSICIANS were licensed by reciprocity on Oct. 11, 1956, to practice medicine in Georgia:

7933	John Henry Anderson	2056 Mason St., Columbus, Ga.
7934	Robert McKinley Beavers	92 Morris Brown Dr., S.W., Atlanta, Ga.
7935	Carl Hannibal Brennan, Jr.	302 E. Victory Dr., Savannah, Ga.
7936	George Lang Burgess, Sr.	807 Athens St., Gainesville, Ga.
7937	Eldon Lee Caffery	Medical College of Georgia, Augusta, Ga.
7938	Bartlette Martin Cheatham	Emory Univ. Hosp., Emory University, Ga.
7939	Alice Graybill Chelton	2474B Morosgo Pl., N.E., Atlanta, Ga.
7940	William Andrew Compton, Jr.	5112 Jerry Lane, El Paso, Texas
1941	Joseph Aquinas Coyle	Veterans Admin. Hosp., Dublin, Ga.
7942	Emmanuel Adams Daneman	Worcester State Hosp., Worcester, Mass.
7943	Jacob Epstein	Grady Hospital, Atlanta, Ga.
7944	Donald Christian Fahrbach	Cleveland, Ga.
7945	Burton McMillan Heine	Batley State Hospital, Rome, Ga.
7946	Stephen Elliott Kramer	Milledgeville State Hosp., Milledgeville, Ga.
7947	Park Chalmers Jeans, Jr.	257-B Greenwood Circle, Decatur, Ga.
7948	Edgar Lovelace Lassetter	Lovelace Clinic, 4800 Gibson Blvd., S.E., Albuquerque, New Mexico
7949	James Moultrie Lee	5463 Speir Street, Savannah, Ga.
7950	William Trent Lucas	1142 Druid Park Avenue, Augusta, Ga.
7951	Thomas Patrick Mahan	Apt. 1210, 2025 P'tree Rd., N.E., Atlanta, Ga.
7952	Isidore Mandelbaum	1846 Phillips Court, East Point, Ga.
7953	Martha Jane McAnulty	1699 Willivee Place, Decatur, Ga.
7954	Robert Lee McCree	406 W. Harvard Ave., College Park, Ga.
7955	John Albert Meier	332 N. Bell Street, Fremont, Nebr.
7956	William N. Morrison	3032 Tuggle Drive, N.E., Atlanta, Ga.
7957	Donald Gene Morton	Box 566, Highlands, N. C.
7958	John Atkinson Owen, Jr.	751 Oxford Road, Augusta, Ga.
7959	John Hancock Thurmond	23 - 1st Avenue, Palmetto, Ga.

Legal Counsel Page (cont'd)

where a woman epileptic was operated on for removal of both ovaries, with the consent of the husband, while she was in a sanitarium. Upon a second confinement the physician removed her uterus. Subsequently she was committed to an insane asylum operated by the state. The husband filed suit against the physician for damages in performing an unauthorized operation charging that she was known to be mentally unsound and incapable of giving consent. No other consent was shown and the doctor was held liable for damages to the husband.

This case emphasizes what I have said before, that in every case of voluntary sterilization the physician should be supported in his opinion that it is necessary by at least one physician and preferably two; he should have the written consent of the person to be

operated on if mentally capable of giving consent, and the husband or wife, as the case may be; and in the case of mentally deficient patients the doctor should have the written consent of one or more of the next of kin closest in relationship.

Space will not permit discussion of the legal problems involved in the voluntary sterilization of a minor, except that if I were a physician I would not perform the operation.

In conclusion let me quote from the *Law of Hospital, Physician and Patient* by Hayt & Hayt, 1947 edition:

"Except as authorized by statute, any person performing, assisting in or otherwise promoting a vasectomy is guilty of a crime, *unless the same be a medical necessity.*" (Italics are the paper's author's.)

321-327 Grant Building.



president's letter

THE HOUSE OF DELEGATES of the A.M.A. has adopted the report of the Council on Medical Services on private practice by medical school faculty members.

The council recommended that medical schools cease to call a faculty member full-time unless he is absolutely full-time, devoting all of his time to the service of the medical school and receiving all his compensation from the salary paid by the medical school. Others would be called geographical full-time, part-time, or voluntary.

The report urged that active liaison committees be developed and continued between county medical societies and medical schools and between state medical associations and medical schools. All patients whether private, medically indigent, or indigent, treated in medical school facilities, should be used for teaching purposes. The report stated that it is preferable for full-time clinical faculty members to be paid an adequate salary by the medical school and not be permitted private practice. If exceptions were necessary because of legal or local conditions, then this faculty member would become a geographical full-time teacher.

The time used for private practice should not interfere with teaching and research responsibilities. Charges should be made for the services rendered by the school to the doctor for his practice. Publicity emanating from a medical school should be in good taste and of the type which has the approval of the general medical community of that area. It is the policy of the A.M.A. that funds received from the private practice of medicine by salaried members of the clinical faculty of the medical schools or hospitals should not accrue to the general budget of the institution and that the initial disposition of fees from paying patients should be under the direct control of the doctor rendering the service.

It is now time for the proper authorities of the state societies to interpret this report as it applies to their local problems and their own individual needs.

Next to the question of the corporate practice of medicine by our medical schools, there ranks in importance problems arising in our hospitals. These problems include the corporate practice of medicine by institutions, the use of residents to practice medicine, charging for their services, the hiring of doctors on a salary and charging for their services, interference with the free choice of physicians by patients, interference with the doctor-patient relationship by the hospital's administrators, improper collection and use of insurance and of fees in compensation cases, and finally, problems arising be-

cause of the improper relationship existing between the administrator and the lay governing board of the hospital on the one hand and the medical staff on the other.

The status of anesthesiologists, pathologists, and roentgenologists in hospitals will be considered in a separate section, as will part of the problems on insurance and compensation cases.

There is no doubt that certain hospitals in the United States, which are not connected with medical schools, are practicing medicine. Some of the hospitals have made rules that under certain circumstances attending physicians are prohibited from accepting fees for personal services, or if they do make charges and fees are collected, the hospital appropriates them for its own use. This was true back in the thirties. In 1949 hospitals in Texas were doing this. In 1950 certain hospitals in North Carolina set up compulsory service plans to apply to all staff members, for the collection of professional fees. Doctors accepted the plan or were dismissed from the staff. The plan yielded a net profit to the hospitals. Some hospitals demanded almost 50 per cent of the physician's income.

Other hospitals took care of patients who had insurance for medical care and billed the companies for services rendered by the resident staff.

Some hospitals have demanded that members of the medical staff make donations to compensate for operating deficits. One hospital even demanded that staff members submit their private books for audit.

The board of one hospital made a rule that the members of the medical staff could not meet for any purpose whatever, even social, without the hospital administrator's being present. Another tried to pass a rule that physicians would have to pay \$500.00 for staff appointments.

There have been many reported incidents in hospitals where one or more doctors on the staff, for their own selfish interests, allied themselves with the lay administrator and the lay board against the majority of the medical staff.

Dr. R. O. Porter, President of the Utah State Medical Association, writes that the hospital-physician relationship was thrown into his lap, and he immediately appointed a special committee to investigate and report to council. A special session of the House of Delegates was called, a resolution passed, and measures taken to straighten out this relationship. This resolution delineated the responsibility and authority of the lay administrator, of the governing board, and of the medical staff. It

reiterated the principle that a physician must not sell his services to any hospital, lay body, organization, group or individual; neither should he undertake any relationship which would make it impossible to render adequate service to his patients. There should be in all institutions a liaison committee between the medical staff and the governing body.

The professional evaluation of the members of the medical staff and of the chiefs of services must be the responsibility of the medical profession. Special services such as anesthesiology, pathology, radiology, and physical medicine are integral parts of the practice of medicine; and physicians in these fields have the same professional status as other members of the medical staff.

The Utah medical society continued this committee to investigate and to process all aspects of the physician-hospital relationship that might occur in the future.

In New York, one physician who was instructed by his hospital administrator to turn over his surgical fees to the hospital for compensation cases took his complaint to the Commissioner of Labor. The Department of Labor enforced the law so that hospitals themselves could not handle compensation cases and receive fees from the services rendered by physicians on the staff.

Other hospitals have used residents to operate on compensation cases, collect the fees, and turn them over to the hospital.

The trustee of one hospital wanted the staff to make examinations on persons engaged in industry at reduced fees for mass examinations. The hospital was to receive the fee—not the doctor. The council of the local society stopped this.

In Cleveland, Ohio, it took from 1949 to 1956 to accomplish what was accomplished in the state of Utah. In the meantime, the hospitals were attempting to take over the practice of medicine.

It appears that an educational program, both for physicians and for hospital officials, is necessary. The administrator of a hospital has the responsibility of coordinating the multiple activities of the institution. He looks to the governing board on one hand and to the professional staff on the other.

The governing body may go deep into the problems of hospital finances and management, but there will be very little opportunity for the members to familiarize themselves with the problems of medicine. Unless there be some special committee appointed, as has been suggested above, the board will have frequent and intimate contact with the administrator and little or no contact with the professional staff. What opinions they have on medical matters are

gained from their personal medical advisors, or from casual contacts, or from the administrator of the hospital. The administration then, under these circumstances, may have undue influence with the board in professional matters. The administrator and the board must be concerned with the overall quality and quantity of the service rendered by a hospital. They must see that there is no dissension in the medical staff, no cliques or favoritism, and that the staff maintains a high quality of medical service. The medical staff itself must be responsible for the qualifications of its members and for the medical services rendered as a whole and to individual patients. Staff members must understand the financial affairs of the hospital and should not demand expenditures which are unreasonable or impossible.

On the other hand, the governing board and the administrator must not tell the physician how to practice medicine, neither must they attempt to assay the professional value of the physician. The rules made by the staff for their own government must be enforced by the administration of the hospital.

In Colorado a special committee of the state association meets periodically with representatives of the Colorado Hospital Association. Committees from local societies meet with the trustees of local hospitals to solve their problems.

A doctor from another state made the statement that unfortunately most medical staffs allow the hospital administrators to be their liaison with the board of trustees. He brings to the medical staff what the trustees have to say, and he takes to the trustees what the staff has to say. This is always a cause of tremendous misunderstanding. Only the doctors of the staff are qualified to present their problems.

From another state, a doctor writes that he has seen statements from hospital administrators saying that the only desirable method of caring for patients is within hospitals, where medical and surgical cases can receive complete care and be sent one bill for the full service in the hospital.

The answers in letters received from all over the United States show that there is an increase in disaffection between the hospital administrators and the lay boards on one hand and the staff physicians on the other. It is a nationwide trend.

Where the medical societies have established committees on the hospital-physician relationships and where these committees are active, there is no trouble. In one state Blue Cross had introduced a plan with a comprehensive contract which provided payment for medical services only if rendered by a hospital employee. The hospitals in these cases would hire physicians and render services so that the patient could receive payment. It must be recognized

New MAG Members

Name	Address	Classification	County
Robert Jeffreys Walker, Jr.	Macon-Bibb Co. Health Dept., Macon	Active	Bibb
Alfred John Aselmeyer	Georgia Dept. of Pub. Health 12 Capitol Square, S.W., Atlanta 3	Active	Fulton
Richard Hardin Johnson	35 4th St., N.E., Atlanta 8	Active	Fulton
Milton Joseph Krainin	1293 P'tree, N.E., Atlanta 9	Active	Fulton
William Dewey Logan, Jr.	Grady Memorial Hospital 36 Butler St., S.E., Atlanta 3	Active DE	Fulton
Thomas L. Linn	City Hospital, Columbus	Active	Muscogee
George Bertling Smith	1243 Forest Ave., Columbus	Active	Muscogee
Leonard Clifton Durrence, Jr.	Blackshear Clinic, Blackshear	Active	Ware

President's Letter (cont'd)

that when a doctor works for a hospital on a salary, he no longer serves his patients but becomes a hospital employee and is required to practice medicine according to the rules and regulations of the hospital, which may not be in accord with his best judgment and conscience.

A.M.A. President Elmer Hess, in his address before the House of Delegates in June 1956, stated that hospital-physician relationship seemed to be going from bad to worse during the past year. Lawsuits and threatened lawsuits have become the order of the day, but no matter who wins in such litigation, each group has damaged itself in the public's opinion. The public never understands what the doctors and the hospitals are fighting about. All disagreements should be settled at the local level and by the *Code of Ethics* of the A.M.A.

It is evidently true that more trouble is occurring in other states than in Georgia and more in the larger cities than in the smaller cities. However, some is occurring here in Georgia, and it is well to recognize that fact and do something about it.

In many of our institutions, not yet definitely established is the dividing line which lies between the authority, prerogatives, and responsibility of the administrator and the lay executive board on one hand and the medical staff on the other.

From various parts of the state, information comes that lay administrators are interfering in various ways with the medical staffs themselves. It has just come to our attention that in one large hospital in the state, it has been the habit of the governing body to accept the administrator's recommendation in making appointments to the staff, including the chiefs of services.

In the spring of this year trouble developed in a hospital in Georgia between the administrator and the governing body on the one hand and the medical

staff on the other. The administrator ignored the wishes of the medical staff with regard to many things which they considered within their province. There was trouble from patients in the hospital about insurance. The hospital would have the patient sign a blanket assignment of benefits and mail this to the insurance company immediately. Later on, when the doctor filled out his form and mailed his assignment to the insurance company, the hospital had already collected it and used it.

One of the most interesting things that happened in connection with this hospital was that the commissioners, apparently with the help of the city manager and the administrator, drew up an ordinance which would have taken away many privileges of the staff of the hospital. This ordinance outlined in detail everything that members of the staff could do and could not do. It was such that it would be almost impossible for some member of the staff to avoid breaking a law every day. Finally, there was attached to this ordinance a penalty clause which stated that any person violating any provision of this ordinance should upon conviction thereof, be punished by a fine not to exceed \$100.00 or by imprisonment not to exceed 60 days, or by both such fine and imprisonment.

Following a protest by the local staff backed up by one from the members of the Executive Committee of the Medical Association of Georgia, this ordinance was done away with.

It seems likely that more trouble is coming in our state if we do not develop liaison committees between the staff and the governing bodies, just as has been done in other states.

Hal M. Davison, M.D.
President
Medical Association of Georgia.

This is the second in a series of articles based on a survey carried out by Dr. Davison. The first appeared in August 1956.

abstracts by georgia authors



Deacon, W. E., Albritton, D. C., Olansky, S., and Kaplan, W.: V.D.R.L. Chancroid Studies. I. A simple procedure for the isolation and identification of *Hemophilus ducreyi*. *Jour. of Invest. Derm.* 26:399-406, 1956.

A simple method for the isolation of *Hemophilus ducreyi* directly from lesions is described. The method makes use of fresh human or rabbit blood clots for primary isolation of *H. ducreyi* from such sources. In addition, the characteristics of newly isolated strains of *H. ducreyi* are described, which makes identification possible.

This paper also points out that virulence of freshly isolated strains of *H. ducreyi* can be maintained by an occasional fresh clot passage. Bacteria having certain features in common with *H. ducreyi* are reported and their significance pointed out.

Kaplan, W., Deacon, W. E., Olansky, S. and Albritton, D. C.: V.D.R.L. Chancroid Studies. II. Experimental chancroid in the rabbit. *Jour. of Invest. Derm.* 26:407-414, 1956.

A total of 256 intradermal inoculations were made with cultures of four strains of *H. ducreyi*. These injections were made into the back and abdominal regions of 16 young rabbits. All inoculations produced lesions. However, the size and intensity of the lesion depended upon the dose, virulence of the strain of organism employed, and upon the individual rabbit.

Repeated attempts to produce lesions in normal rabbits by rubbing virulent cultures into scarified areas of skin met with failure in every case. In order to produce lesions in rabbits by rubbing cultures into broken skin, previously sensitized rabbits must be employed. However, the size and intensity of such lesions depend on the virulence of the strain used. The authors feel that rabbits may be employed in testing the efficacy of topically applied medications for preventing chancroid infections. However, because of the necessity to employ previously sensitized rabbits, results from such studies must be interpreted with caution.

Kaplan, William, Deacon, W. E., Olansky, S. and Albritton, D.C.: V.D.R.L. Chancroid Studies. III. Use of Ducreyi skin test vaccines on rabbits. *Jour. of Invest. Derm.* 26:415-419, 1956.

Vaccines were prepared from four strains of *H. ducreyi* (two virulent and two avirulent) by growing the organism in a medium containing rabbit serum in place of whole blood. Such vaccines have the advantage of being free of rabbit red cell debris. The intracutaneous inoculation of killed suspensions of *H. ducreyi* was shown to produce focal reactions of induration and hyperemia in previously infected rabbits. No qualitative or quantitative differences in antigenicity could be detected in vaccines prepared from virulent or avirulent strains of *H. ducreyi*.

This study again points to the possibility of utilizing rabbits for assaying potency of Ducrey skin test antigens. In addition, the study again points to the possibility of employing rabbits to investigate the basic mechanism by which cutaneous sensitivity develops following infection with *H. ducreyi*.

Boyd, Montague L., 563 Capitol Avenue S.W., Atlanta, Ga. "Twenty-eight Years of Suprapubic Drainage Following Injury to the Spinal Cord" *South. M.J.* 49:815-816 (August) 1956.

The reported case is after 28 years in good health, holds a part time job, and takes care of her own room. The wound is healthy, there are no stones present, and the phenolsulphonphthalein test shows an output of 38.7 per cent in 30 minutes.

This was a girl of 17 who has had sympathetic, efficient, and intelligent care, things which are necessary to insure the best results in suprapubic drainage. Cleanliness is essential, as is the avoidance of irritation of and pressure on the tissues involved in the paralysis.

At operation the bladder should be infolded about the suprapubic tube, and the abdominal muscles kept together with stay sutures so as to insure an adequate thickness of tissue between the skin and bladder mucosa. Leakage of urine about the tube is avoided if for a week or more gentle suction through the suprapubic tube is maintained by making a loop in the lower end of the drainage tube so that there will be constantly a column of fluid in the tube.

Leakage from the urethra rarely occurs even in later years where there is muscle atrophy, and rarely even in women in spite of the relaxation of the muscles of the vesical orifice and the urethra.

Long continued urethral drainage produces undesirable changes in the urethra and bladder neck even in women. In men, long continued catheter drainage not only produces chronic urethritis with some absorption of toxic products from the highly vascularized urethra, but causes prostatitis and often seminal vesiculitis and epididymitis.

Equen, Murdock, 144 Ponce de Leon Ave., N.E., Atlanta 8, Ga. "The Rehabilitation of the Laryngectomee" *Arch. Otolaryng.* 64:1-3 (July) 1956.

It is a shock to even the most stolid man to learn that, because of cancer, he must sacrifice his larynx: he envisions a future of miserable existence. Accordingly, as soon as we inform a patient that laryngectomy is necessary, we introduce to him a man without a larynx who has mastered pharyngeal speech, one with a cheerful, outgoing personality.

The laryngectomee explains to the neophyte that he will be able to talk again. He will not be able to swim or do heavy manual labor, but he will almost

certainly be able to return to his former occupation, even preaching or practicing law. He and other laryngectomees call on the patient often during his convalescence to boost his morale.

The quickest way to learn to talk again is with an electric larynx or with a reed-type larynx. The semi-illiterate with a low I. Q. and the elderly man who is growing deaf may have to be content with these. The ambitious, otherwise healthy man, however, with proper instruction and practice, can perfect himself in pharyngeal speech in a relatively short time.

Georg, Lucille K., Ph.D., Public Health Service, Chamblee, Ga.; Gladys Torres, Ph.D., San Juan, Puerto Rico. "A Human Case of *Trichophyton Gallinae* Infection" *Arch. Dermat.* 74:191-197 (August) 1956.

The second case of human infection due to *Trichophyton gallinae* has been reported. *T. gallinae* is commonly the cause of ringworm of chickens, also known as "favus" or "white comb."

The isolation of *T. gallinae* from a scalp lesion in a four-year-old Puerto Rican child led to an investigation as to the source of the infection. It was found that the chickens with which the child played showed scaliness on their combs, and *T. gallinae* was isolated from one of the birds. Experimental infections in chickens and guinea pigs are described.

Flanagin, W. S., Medical College of Georgia, Augusta, Ga. "Free Composite Grafts from Lower to Upper Lip" *Plast. & Reconstruct. Surg.* 17:376-380 (May) 1956.

The flat upper lip is a common problem for the surgeon who does secondary cosmetic repair on bilateral, and even unilateral hare-lip patients. The upper lip will be tight and the lower lip will protrude ahead of it, when viewed from the side. This is the reverse of normal.

In this experiment a daring one stage repair is done by completely detaching a full-thickness composite wedge of tissue from the center of the lower lip and placing it into an opened full-thickness defect of the upper lip. Four of these grafts have been done and all have survived with restoration of the profile line to normal. The grafts used were up to one cm. wide at the mucocutaneous junction.

In these old hare-lip cases it is important that we get a noticeable improvement in their appearance when a surgical attempt is made. For otherwise we will damage their morale. If we could just improve their facies so that every "Tom, Dick, and Harry" who comes face to face with them on the street would not recognize that they had been born with a hare-lip, we would have done them a great service.



physician's bookshelf

Books Received

Commission on Chronic Illness, *Chronic Illness in the United States, Vol. II, Care of the Long-Term Patient*, Harvard University Press, Cambridge, Mass., 1956, 606 pp., \$8.50.

Mellan, Ibert, and Eleanor Mellan, *Dictionary of Poisons*, Philosophical Library, New York, 1956, 150 pp., \$4.75.

Meschan, Isadore, M.D., *Roentgen Signs in Clinical Diagnosis*, W. B. Saunders Company, Philadelphia, 1956, 1058 pp., 780 fig., \$20.00.

Pillsbury, Donald M., M.D., Walter B. Shelley, M.D., Ph.D., and Albert M. Kligman, M.D., Ph.D., *Dermatology*, W. B. Saunders Company, Philadelphia, 1956, 1331 pp. 564 figs., \$20.00.

Stopes, Marie Carmichael, Ph.D., *Sleep*, Philosophical Library, New York, 1956, 149 pp., \$3.00.

Young, Agatha, *Scalpel, Men Who Made Surgery*, Random House, New York, 1956, 311 pp., \$5.00.

Immunization Information for International Travel, U. S. Dept. of Health, Education, and Welfare, Washington, D. C., Government Printing Office, 25¢.

Wells, Benjamin B., M.D., Ph.D., *Clinical Pathology, Application and Interpretation*, Second Edition, W. B. Saunders Company, Philadelphia, 1956, 488 pp., 25 fig., \$8.50.

Reviews

Duncan, Garfield G., M.D., *A MODERN PILGRIM'S PROGRESS for Diabetics*, W. B. Saunders Company, Philadelphia, 1956, 222 pp., \$2.50.

This little book has many things to recommend it. First, it is small, pocket sized and easy to read. Second, it is written by an outstanding physician in the field of diabetes, the Clinical Professor of Medicine, Jefferson Medical College, Philadelphia, Pennsylvania. Third, it presents the subject in a most interesting and instructive fashion.

It tells the story of a girl who became afflicted with diabetes. Then, it follows her through all her problems and difficulties as she learns more and more about the care and control of her disease. There is not a problem in the field of diabetes that this girl does not have explained to her—from the introduction to elementary care, through pregnancy and labor. The book reads like a novel rather than a textbook. As such, it is much easier for a patient to follow and learn about the disease. Physicians, too, will benefit by learning the proper approach in explaining the management of diabetic problems.

The last third of the book emphasizes the more technical details in the management of diabetes in a somewhat textbook form. This includes information on diet, insulins, reactions, coma, care of the feet and skin, etc. In fact, it covers everything a diabetic should know and that is not narrated in the story.

This book will be of definite value to physicians, but more so to diabetic patients of an intellectual level capable of understanding and appreciating what is being explained. It is much more easily read and of

much more interest than a textbook, though at the same time it contains all of the information to be found in any standard textbook.

Christopher J. McLoughlin, M.D.

Major, Ralph H., M.D., and Mahlon H. Delp, M.D.: *PHYSICAL DIAGNOSIS*, W. B. Saunders Company, 1956, 358 pp., \$7.00.

The plethora of textbooks of physical diagnosis indicate the general dissatisfaction with all. Unfortunately, the more scholarly and encyclopedic tomes have been sacrificed to brevity and are out of print. Their replacements often presumptuously disdain to give the critical reader source material for some remarkable statements. Dr. Major's book has entered its 5th edition partially because it easily outstrips a slow field. It does, however have its merits. It is entertainingly written, has an excellent but somewhat dated bibliography, and the historical perspective adds immeasurably to its interest. The revision, however, is not entirely successful. Although the new format is attractive, the text has been rather uncritically shortened. The retention of a long discussion on the oscillometric determination of blood pressure, for example, in view of the inadequate treatment of the retina, palpation of the spleen, and the third heart sounds are cases in point. Most specialists will quarrel with statements in their sections. The more than 500 illustrations are in general good, although a few have more the charm of antiquity than of lucidity. The organization and material, however, are sufficient for the avowed purpose of sophomore medical students. The more mature physician will find little new (and he should), and its main value will be to refresh him on simple but forgotten points of other specialties.

A. Calhoun Witham, M.D.

Allen, Edgar V., M.D.; Barker, Nelson W., M.D.; and Hines, Edgar A. Jr., M.D., *PERIPHERAL VASCULAR DISEASES*, W. B. Saunders Company, Philadelphia, 1955, 825 pp., 316 illustrations, \$13.00.

In every field of surgery one book seems to stand alone as the "Bible," and to the physicians who have an interest in peripheral vascular disease the "Bible" is the book written by Allen, Barker and Hines. The second edition of *Peripheral Vascular Diseases* is most welcome as the advances in this field have been active and rapid since the first edition was published in 1946.

The authors have attempted to classify peripheral vascular diseases in a simple fashion to discourage the practice of grouping all diseases of the peripheral vessels under one heading—peripheral vascular disease. The chapters are arranged in a fashion to facilitate reference to a particular subject. Functional and organic diseases of the arteries are discussed in the first chapters, followed by diseases of the veins. A chapter on the poorly understood entity, Lymphoedema, is included in an effort to make the book complete.

The section devoted to surgical treatment is excellent, as individual surgeons with wide experience in the treatment of specific diseases express their viewpoints. Numerous references are appended to each chapter; however, the authors have not hesitated to express their opinions.

In revising their book the authors have kept abreast of recent advances by including and discussing entirely

new subjects such as: technic of aortography, coarctation of the aorta, purpura, hypertensive ischemic ulcers of the leg, technics of sympathectomy, non-vascular operation for intermittent claudication, the surgical treatment of varices, surgical treatment of aortic aneurysms, and surgical treatment of vascular injuries. I believe the practicing physician as well as the research worker will find this book a useful addition to his bookshelf.

M. F. Bryant, M.D.

PROCEEDINGS, WORLD CONGRESS OF ANESTHESIOLOGISTS, September 5-10, 1955, Scheveningen, The Netherlands; Burgess Publishing Co., Minneapolis, 1956, 321 pp.

The book contains most of the papers which were presented at the World Congress of Anesthesiologists held in Scheveningen, The Netherlands, September 5-10, 1955.

As one might expect, the papers are abstracted but do contain the majority of illustrations used in the original presentations. The papers are grouped under a number of headings so that the volume contains the outline of the proceedings of the meeting. The entire volume is printed in the English language, although some of the work was done in foreign countries.

Items receiving special attention at the meeting were such phenomena as artificial hibernation, hypothermia, and hypotension as used during Anesthesia. Quite a number of the articles included in the volume have to deal with these subjects. There is also a quantity of material regarding the various muscle relaxant drugs and the new mechanisms for controlled ventilation with machines.

Although not an outstanding literary contribution, this volume does provide its reader with an excellent outline of the material presented during this international meeting.

Lester Rumble, Jr., M.D.

Sadove, Max S., M.D., and James H. Cross, M.D., THE RECOVERY ROOM, W. B. Saunders Company, 1956, 597 pp., \$12.00.

This volume contains 597 pages. As the title would indicate, it is a treatise dedicated to immediate post-operative management, and it contains contributions by 24 authorities other than the authors listed.

The first portion of the book deals with the general considerations involving the establishment and management of a recovery room. Several suggestions are made regarding the formulation of policies and practices in such a room in addition to the arrangement of the physical facilities. Suggestions are made for the number and type of personnel that should manage such an undertaking.

Following the discussion of the principles involved in the recovery room management, there is a section devoted to general care of the post-operation patient with particular attention to shock, circulation, respiration, and nutrition.

The greater portion of the book is divided into specific outlines and discussions of the complications which follow particular types of surgery. These discussions are divided into chapters that deal with a particular region of the body; for instance, "Surgery of the Chest." Each of these sections pays particular attention to the common and uncommon complications which occur following operations in this region.

Throughout the volume, there are a number of illustrations, graphs, and suggested outlines of management which are excellent. The volume is well written and well

organized. It should be of value, particularly to anesthesiologists as well as to other individuals associated with recovery room care. It would be an invaluable volume to be found in the library of any hospital whether they operate a recovery room or not.

Lester Rumble, Jr., M.D.

Hingson, Robert A., M.D., and Louis M. Hellman, M.D., ANESTHESIA FOR OBSTETRICS, J. B. Lippincott Company, Philadelphia, 1956, 344 pp., \$12.50.

This book is co-authored by two of the outstanding men in Obstetrics and Anesthesia today. The title however is misleading in its incompleteness. The book covers all of the physiological and psychological aspects as well as recommended dosages, techniques, contraindications, etc.

In reading through the book one gets the impression of repetition, and such is the case in numerous instances, yet each time it fits into the current topic under discussion.

Obviously the authors take little stock in the teachings of Grantly Dick Read, and yet they emphasize the psychological aspects of the fear of pain during childbirth.

The chapter on "Anatomic and Physiologic Considerations" is extremely interesting and well written. It seems to be the highpoint of the book. The chapter on "Control of Pain in Maternal and Fetal Complications" covers a great deal of abnormal obstetrics and their management in addition to anesthesia for these conditions.

The value of the book as a reference would outweigh its value as a text.

Joseph L. Girardeau, M.D.

Sodeman, William A., PATHOLOGIC PHYSIOLOGY: MECHANISMS OF DISEASE, W. B. Saunders Company, Philadelphia, 1956, 963 pp.

According to the Editor, this "monograph" of approximately 1000 pages tries to bridge the gap between text books of physiology and medicine. However, in this book too much of the abutment and too little of the bridge is described. The book is overloaded with material found in the standard texts of bacteriology, physiology, anatomy, and medicine. Much space is wasted with such statements as "The endocardium is a smooth lining membrane composed of a layer of simple squamous endothelium and an under layer of connective tissue." I think the authors should assume the reader has some knowledge of basic sciences.

According to the preface, the authors do not aim at the completeness of text books of physiology and medicine. But the book suffers from their obvious fear of leaving something out.

The multiple approach causes much unnecessary duplication. Different sections approach the subject from genetics, etiologic aspects, and organ systems as well as metabolism in general.

The overlap is made worse by dividing organ systems among too many authors. It would seem unnecessary to have five authors writing chapters on the cardio-vascular systems and five other authors on the digestive system.

I enjoyed the last 15 chapters more than the earlier chapters. I thought the following chapters particularly well done: Electrocardiography by Dr. Johnston; Heart by Dr. Hull; Liver by Dr. Ingelfinger, and Blood by Dr. Castle.

In closing, I would ask, is it really necessary to have so many chapters of 10 to 25 pages written by two authors or is this pretext to embellish the list of contributors?

Goodloe Y. Erwin, M.D.

THE ASSOCIATION

Hospital Care Commission

September 13, 1956

THE SECOND MEETING of the Georgia Hospital Care Commission was called to order by T. F. Sellers, Chairman, Ex-Officio. The following business was transacted:

1. Members of the Commission and other invited guests were introduced by the Chairman, Dr. Sellers:

Members of the Commission present: Dr. Sellers, Atlanta, Director of the Georgia Department of Public Health; Helen W. Bellhouse, Atlanta, member ex-officio, Director of the Division of Maternal and Child Health, Georgia Department of Public Health; Mr. Frank W. Allcorn, Warm Springs, representative of the State Association of County Commissioners; Mr. Wiley P. Jackson, Macon, representative of the Georgia Hospital Association; Mr. Oscar S. Hilliard, Fort Oglethorpe, representative of the Georgia Hospital Association; W. P. Harbin, Jr., Rome, representative of the Medical Association of Georgia; Milford B. Hatcher, Macon, representative of the Medical Association of Georgia; Virgil B. Williams, Griffin, representative of the Medical Association of Georgia; Mr. M. M. Monroe, Waycross, representative of the Georgia Association of Hospital Governing Boards; Mr. F. L. Baker, Jr., Rome, representative of the Georgia Association of Hospital Governing Boards; and Mr. W. E. Uzzell, Atlanta, Secretary to the Commission, Division of Hospital Services, Georgia Department of Public Health.

Members absent: Mr. J. H. Slagle, Calhoun, representative of Association of County Commissioners; Judge Alan Kemper, Atlanta, Vice Chairman, ex-officio, Director, Georgia Department of Public Welfare; and Grady N. Coker, Canton, Consultant to the Commission, Administrator, Coker's Hospital.

Invited guests present: Mr. Frank Daniels, Atlanta, *Atlanta Journal*; Mrs. Helen Gillespie, Atlanta, Executive Secretary, Georgia Hospital Association; Mr. Burwell W. Humphries, Atlanta, President, Georgia Hospital Association; Mr. John Kiser, Atlanta, Assistant Executive Secretary, Medical Association of Georgia; Mr. Harold Parker, Atlanta, Director, Division of Social Administration, Georgia Department of Public Welfare; Rufus F. Payne, Augusta, Director, Eugene Talmadge Memorial Hospital; David Henry Poer, Atlanta, Secretary, Medical Association of Georgia; and R. C. Williams, Atlanta, Director, Division of Hospital Services, Georgia Department of Public Health.

2. The minutes of the last full meeting of the Commission (May 23, 1956) were read by the secretary and adopted without discussion.

3. Helen W. Bellhouse introduced the subject of the two legislators that were to be appointed by Governor Marvin Griffin (after the September 12, 1956 primary) to serve on the Commission. It was moved and carried that this request be made of the Governor and that such

members to be placed on the Legislative Committee, of which Mr. M. M. Monroe of Waycross is Chairman.

4. The Chairman called on Mr. Frank W. Allcorn for a report of the activities of the Survey Committee. A preliminary draft of the survey was distributed to each member for discussion. During the reading of the preliminary draft, the following comments and suggestions were agreed to by those present:

- (a) The proper utilization of Grady Memorial Hospital (charity hospital) data in the study was discussed at some length with the agreement that the inclusion of such data had a marked effect on the results, and that the extent of the effect of Grady data should be identified in the form of footnotes.
- (b) It was agreed that more emphasis would be given to City-County contributions other than the lump sum direct grants made to hospitals as listed in Table III.
- (c) The suggestion was adopted that all types of prepayment—commercial as well as non-profit plans—should be more fully developed with less emphasis on the Blue Cross Plan.
- (d) The suggestion was adopted that all recommendations be omitted from the main body of the report and incorporated in a new section entitled "Recommendations".

4. The Chairman was authorized to designate the chairman of each committee (Survey, Publicity, Coordinating, and Legislative) to act as a Joint Committee on Recommendations. This committee was also requested to study other state hospital care plans and to arrange for visitations to those states, if desirable to do so. Mr. Allcorn was elected chairman of the Joint Committee on Recommendations.

5. It was recommended that the full report with the above corrections, and with further editing, be resubmitted by mail to each member with a request for further comments within one week. The full report is to be re-submitted to the full commission, after completion of the section on recommendations to be made by the Joint Committee, appointed for that purpose.

6. Further Meetings:

- (a) October 18, 1956, at 9:00 A.M. at the Dempsey Hotel, Macon, the Joint Committee on Recommendations was scheduled to meet. It was suggested that as many as possible of the Joint Committee assemble the night of October 17, 1956 (Dempsey Hotel) to submit a preliminary draft of the recommendations, prior to the 9:00 A.M. meeting.
- (b) The next meeting of the full Commission is to be held at a place and time to be determined by the Joint Committee on Recommendations and Legislation.

7. *Adjournment:* After an expression of appreciation to the Medical Association of Georgia for the excellent luncheon, upon motion the meeting was adjourned at 3:30 P.M.

W. E. UZZELL, *Secretary*

Comments on the called meeting of the MAG Council are found on the Executive Secretary's Page, 453.

ANNOUNCEMENTS

Emory University School of Medicine Postgraduate Session on Liver Diseases—December 14-15, 1956, Room 213, Physiology Building, Emory University, Ga. This is the second of four postgraduate sessions planned. Guest speakers include Franz J. Ingelfinger, M.D., Boston Univ. School of Medicine, and Jack D. Myers, M.D., Univ. of Pittsburgh School of Medicine. Discussions will include topics on Fundamentals of Liver Diseases; Acute Liver Disease with emphasis on viral, toxic and amoebic hepatitis; and Chronic Liver Disease. Registration fee: \$20.00. Authorized by AAGP for 11½ hours postgraduate credit, Category I.

Two-week Course in Radiological Safety—January 7 to 18, 1957, New York University Post-Graduate Medical School. Course designed for industrial physicians, industrial engineers, etc. There will also be an optional two-week laboratory session from January 21 to February 1. For further information write to the Dean, NYU Post-Graduate Medical School, 550 First Avenue, New York 16, N. Y.

Sister Elizabeth Kenny Foundation Scholarships—A program to promote work in the field of neuromuscular diseases, the scholarships are designed for scientists at or near the end of their fellowship training in either basic or clinical fields concerned with the broad problem of the neuromuscular diseases. Scholars will be appointed annually. Each grant will provide a stipend for a five year period at the rate of \$5,000 to \$7,000 a year depending upon the qualifications. Candidates from medical schools in the United States and Canada will be eligible. Inquiries should be directed to Dr. E. J. Huenekens, Medical Director, Sister Elizabeth Kenny Foundation, 2400 Foshay Tower, Minneapolis 2, Minn.

American Medical Association Film Library—A revised list of films available through the library has been prepared, and copies are available upon request from Motion Pictures and Medical Television of the American Medical Association. The

catalog lists 89 medical films suitable for showing to medical societies, hospital staff meetings, and other scientific groups. It also includes 45 health films of interest to physicians who may be called on to speak before lay audiences.

American Geriatrics Society Graduate Symposium on Geriatric Medicine—Waldorf-Astoria, New York City, November 19 and 20, 1956. No registration fee, all physicians invited. Twelve (12) hours postgraduate study credit, Category I, given. Write Mrs. Ralph Scaffner, Reservation Manager, Waldorf-Astoria, 50th Street and Park Avenue, New York 22, N. Y.

Other Courses offered by the New York University Post-Graduate Medical School—Safety Practices in the Operating Room, December 14 and 15, 1956, and March 1 and 2, 1957 (repeat). *Pediatric Cardiology*, December 3-7, 1956, designed for the pediatrician, general practitioner, and others faced with the problem of cardiac children. *Infertility*, December 3-5, 1956, will deal with the problem of sterility as related to both husband and wife. For further information write to the Dean, Post-Graduate Medical School, 550 First Ave., New York 16, N. Y.

Dermatologic Research and Teaching Fellowships—New York Skin and Cancer Unit of the New York University-Bellevue Medical Center. Fellowships available on two levels: for dermatologists who have completed their three year, full-time training in dermatology and who are desirous of a research or teaching career in special fields of dermatology—immunology, mycology, oncology, physiology, radiation (including radioactive isotopes). This fellowship pays \$7,000 a year. The second type, at \$5000 per year, is available to graduate students or residents who have completed their basic science year at a recognized institution and who plan to do research or to assist in teaching in special fields. Applicants should apply to: The Director, Service of Dermatology, New York Skin and Cancer Unit, 330 Second Avenue, New York 3, N. Y.

Urology Award—The American Urological Association offers annual award of \$1000 for essays on the result of clinical or laboratory research in urology. Competition limited to urologists who have been graduated not more than 10 years, and to hospital internes and residents doing research work in urology. For full particulars, write the Executive Secretary, William P. Didusch, 1120 North Charles St., Baltimore, Md. Essays must be in his hands before December 1, 1956.

Van Meter Prize Award—The American Goiter Association offers the award of \$300.00 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The essays should cover either clinical or research investigations, should not exceed 3,000 words, and must be presented in English. Duplicate typewritten copies, double spaced, should be sent to the Secretary, Dr. John C. McClintock, 149½ Washington Ave., Albany 10, N. Y., not later than January 15, 1957. For further information, write to Dr. McClintock.

Fiske Essay on Infertility—The Caleb Fiske Prize of the Rhode Island Medical Society will be given this year for the best dissertation on "The Present Day Treatment for Infertility." The paper should be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of \$350 is offered. Essays must be submitted by January 1, 1957. For complete information, write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis St., Providence 3, R. I.

American College of Physicians Postgraduate Courses—The following courses will be offered in the fall of 1956: Recent Advances in Cardiovascular Disease, Clinical Neurology, Internal Medicine, Recent Advances in Internal Medicine, Selected Problems in Internal Medicine, Gastroenterology, Electrocardiography, Pathologic Physiology of the Blood Dyscrasias. For information as to dates and location of each course, write to The American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa.

The American College of Physicians is presenting eight postgraduate courses in the fall and winter of

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1956-57. Four have been given, and the remaining four are as follows: *Selected Problems in Internal Medicine*, November 26-30, 1956, University of Oklahoma School of Medicine, Oklahoma City, Okla. Director: Stewart G. Wolf, M.D. Fee: members, \$30.00, non-members, \$60.00. *Gastro-Enterology*, December 3-7, 1956, University of Pennsylvania Graduate School of Medicine, Philadelphia. Director: Henry L. Bockus, M.D. Fee: members, \$30.00, non-members, \$60.00. *Pathologic Physiology of the Blood Dyscrasias*, February 18-22, 1957, Washington University School of Medicine, St. Louis, Mo. Directors: Carl V. Moore, M.D., William J. Harrington, M.D., and Edward H. Reinhard, M.D. Fee: members, \$30.00, non-members, \$60.00. *Basic Concepts of Clinical Electrocardiography*, December 3-8, 1956, University of Utah College of Medicine and Salt Lake General Hospital, Salt Lake City, Utah. Director: Hans H. Hecht, M.D. Fee: members, \$30.00, non-members, \$60.00.

Southern Branch, American Public Health Association Meeting, May 29-31, 1957, Asheville, N. C. Delegates are urged to write early for reservations. Address applications to William D. Turner, Jr., George Vanderbilt Hotel, Asheville, N. C. Negro applications should be sent to Mrs. H. K. Harrison, 23 Eloise St., Asheville.

DEATHS

GEORGE Y. MASSENBURG, Macon, died on September 1, 1956, in Rochester, Minn. Funeral services were held in Macon on September 3rd, at Christ Episcopal Church.

Dr. Massenburg was born in Towson, Maryland, the son of Dr. and Mrs. R. C. Massenburg. He received his education at the University of Maryland and served his internship in Baltimore and his residency in surgery at the San Thomas Hospital in Panama.

He came to Macon in 1919 and was instrumental in organizing the clinic where he practiced. He was a veteran of World War I, a member of Christ Episcopal Church, the American College of Surgeons, BPO Elks, the Lions Club, the Moose Club, and the American Legion.

Surviving Dr. Massenburg are his wife; two daughters, Mrs. Fred H. Brannan, and Mrs. William A.

Strother; one son, George Y. Massenburg, Jr., M.D., Macon; and six grandchildren.

Pallbearers included the following Macon physicians: C. B. Clay, Jr., Charles Benton, Henry H. Tift, John I. Hall, J. E. Clay, V. H. McMichael, W. D. Hazelburst, Waddell Barnes, Walter Homeyer, Harry Craddock, Wallace Bazemore, Paul Gates; and other members of the Bibb County Medical Society formed an honorary escort.

JAMES VIRGIL ROGERS, SR., Cairo, died on August 25, 1956, at the age of 64. He had been ill for three weeks.

Dr. Rogers was born in Claxton on July 20, 1892. He lived in Cairo and practiced medicine there for the last 33 years. In addition to his practice of medicine he was also active in the community as a member of the Grady County School Board (since 1931), as Sunday School Superintendent of the First Methodist Church, and as a member of the church's Board of Trustees. He was a Mason and a former Kiwanian.

Dr. Rogers graduated from Emory at Oxford and the Emory University School of Medicine. He was a member of the Grady County Medical Society.

Surviving are his wife, the former Miss Ruth Collins; two sons, James V. Rogers, Jr., M.D., Atlanta, and Mr. Edgar Rogers, Tallahassee, Fla.; and one daughter, Mrs. Robert L. Heisler, Gainesville, Fla.

Funeral services were held at the First Methodist Church of Cairo, with burial in Brewton Cemetery, Claxton. The doctors of Cairo were honorary pallbearers.

In memory of Dr. Rogers the people of Cairo have donated an oxygen tent for use in the Grady County Hospital.

INMAN PARKER SMITH, Rome, died October 5, 1956, after a short illness.

Dr. Smith was born in Pineville, Ky., January 15, 1904, the son of Dr. and Mrs. John Inman Smith. He attended the University of Tennessee and was graduated from the University of Louisville, where he was a member of the Phi Beta Kappa Fraternity.

Dr. Smith was a member of the Rome First Baptist Church, the

Scrap Iron Class of the Church, Coosa Country Club, Nine O'Clock Cotillion, American Academy of Pediatrics, and the Kiwanis Club.

Surviving him are his wife, the former Miss Helen Avery; two daughters, Misses Marjorie and Elizabeth Smith, Rome; two sisters; and his mother.

Funeral services were held on October 7, 1956, with interment in Sunset Hills Memorial Gardens. Among the pallbearers was George Christenberry; members of the Floyd County Medical Society formed the honorary escort.

SOCIETIES

The semi-annual meeting of the SECOND DISTRICT MEDICAL SOCIETY was called to order by the president, Walter P. Rhyne, Albany, at 3:00 p.m., October 4, 1956, at Radium Springs, Albany. Julian B. Neel, Albany, secretary-treasurer of the society, read the minutes of the previous meeting; these were approved as read. Dr. Rhyne introduced Mr. Milton D. Krueger, Executive Secretary of the Medical Association of Georgia, who reported on the activities of the Headquarters Office. Mr. Krueger discussed (1) insurance problems affecting the profession; (2) problems with regard to ethics which affect the profession; and (3) Association Council and committee activity. Speakers at the scientific session were as follows: William H. Grimes, Atlanta—"Management of Breech Presentation in Pregnancy and Labor"; Charles D. Hollis, Jr., Albany—"Value and Limitations of the Electrocardiogram in Medical and Surgical Patients"; George Dillinger, Thomasville, Councilor from the Second District—"Medical Care Program for Armed Service Dependents, Public Law 569"; and H. B. Jenkins, Donalsonville—"The Doctor and Social Security". The Second District Medical Society went on record as being in favor of compulsory social security coverage for the physicians in the district. A. G. Funderburke, Moultrie, and J. A. Redfearn, Albany, were nominated for election to the State Board of Health. A social hour was held at 5:30 p.m. followed by dinner at 6:45 p.m. for the members of the society and their wives.

The Fall meeting of the SEVENTH DISTRICT MEDICAL SO-

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CIETY was held at 2 p.m., Wednesday, September 26 at the Dalton Country Club, Dalton. The meeting was called to order by Ralph N. Johnson, Rome, president, and the following scientific papers were read and discussed: "The Diagnosis and Treatment of Post-Meningitic Subdural Collections of Fluids," John Looper, Dalton; "Common Complications of Anesthesia", Larry Cauthen, Rome; "Modern Therapy of Hypertension", Robert Coggins, Marietta; "Open Healing of Tuberculous Cavities", Raymond F. Corpe, Rome. Hal M. Davison, Atlanta, President of the Medical Association of Georgia, discussed the activities of the committees and Council of the Association. He discussed the proposed revisions of the Medical Practice Act of Georgia and the organization of the new medical Education Committee. Mr. John F. Kiser, Assistant Executive Secretary, discussed the medicare program as it concerns Public Law 569. Following the program, a delightful social hour and barbecue were held at the Country Club, sponsored by the Whitfield County Medical Society.

The semi-annual meeting of the EIGHTH DISTRICT MEDICAL SOCIETY was held 2 p.m., Tuesday, October 9 at the Community House in Jesup. The meeting was called to order by Joe Mercer, Brunswick, president. The invocation was read by James M. Hicks, Brunswick, vice-councilor, and the welcome address was given by Fred M. Harper, Jesup, President of the Wayne County Medical Society. The scientific program included papers on "Management of Acute Head Injuries" by George R. Gish, Jr., Emory University, and "Management of Lumps in the Neck" by J. Elliott Scarborough of Emory University. Carter L. Meadows, Jesup, presented a case. During the business session the Councilor's report was given by F. G. Eldridge, 8th District Councilor of Valdosta. Dr. Eldridge discussed the effect of Public Law 569 on the practice of medicine in Georgia and described the work of Council and its committees in regard to this program on medical care for dependents of the armed services. Hal M. Davison, Atlanta, President of the Medical Association of Georgia, discussed other activities of the Association, and Mr. John F. Kiser, As-

sistant Executive Secretary, reported on legislative activities. During the period of discussion, Dr. Mercer and others discussed problems with hospitals in the Eighth District, and on a motion duly made and seconded, it was voted to authorize the president to appoint a Hospital Committee of the 8th District Medical Society, to be composed of one member of the staff of each hospital in the district. The problem of social security for physicians was also discussed, and it was agreed that the MAG Headquarters Office would assist the incoming officers in securing a speaker on this subject for the April meeting. The following officers were elected: W. Loomis Pomeroy, president; Robert A. Pumpelly of Jesup, vice-president. Sage Harper, Douglas, the incoming secretary, informed the society that his term did not expire until 1957. Following the business meeting, a social hour and dinner sponsored by the Wayne County Medical Society was held at the Palmetto Club in Jesup.

The Fall session of the NINTH DISTRICT MEDICAL SOCIETY was called to order at 2:30 p.m., Wednesday, September 19, at the Elks Club, Gainesville, by Raleigh Garner, Gainesville, president. The invocation was presented by John Reed, Gainesville, and the Address of Welcome was given by Barton A. McCrum, Gainesville, President of the Hall County Medical Society. Following the business session in which activities of the Medical Association of Georgia were outlined by Hal M. Davison, president, and Mr. John F. Kiser of the MAG Headquarters Office, the following scientific papers were presented: "Pyelonephritis Etiology and Treatment" by W. Perrin Nicolson, III; "Bleeding in the Third Trimester of Pregnancy" by John K. Burns, III; and "Arterial Aneurysm" by John Howard, Emory University. Charles R. Andrews, Canton, and Paul Scoggins, Commerce, were nominated as councilor and vice-councilor respectively for the term beginning May 1st, 1957. Dr. Andrews is the current incumbent acting as Councilor of the Ninth District. Following the business and scientific sessions, a social hour and dinner were held in the Elks Club.

At the September meeting of the BIBB COUNTY MEDICAL SOCIETY, Raymond F. Corpe, Rome,

superintendent of the Battey State Hospital, addressed the members on recent developments of drug therapy in the treatment of tuberculosis. The meeting was sponsored jointly by the society and the Bibb County Tuberculosis Association; Dr. Corpe was introduced by Sam E. Patton, Macon; and the meeting was arranged by Jule C. Neal, Jr., Macon.

At a recent meeting of the COBB COUNTY MEDICAL SOCIETY, Murdock Equen, Atlanta, spoke on cancer of the larynx. He said that five per cent of all cancers detected are of this type, and 95 per cent, of the cases occur among heavy smokers. For more news of Cobb County see the Executive Secretary's Letter, page 453.

The DOUGHERTY COUNTY MEDICAL SOCIETY sponsored an all-day session on September 20th known as the Southwest Georgia Medical Seminar. The meeting was held at the Phoebe Putney Memorial Hospital in Albany and is intended to be an annual affair. The meeting was conducted entirely by members of the county society and consisted of clinics and pathological and x-ray conferences. Demonstrations of the latest surgical techniques were held; there was a symposium on gallbladder diseases; and a number of scientific papers were presented. David Merren was chairman of the meeting.

The FULTON COUNTY MEDICAL SOCIETY met on September 6th for what turned out to be the biggest meeting in the society's history. Speakers at the scientific session were Dan B. Kahle, Donald W. Singleton, Charles F. Stone, and T. Sterling Claiborne, all of Atlanta. The members voted on a proposed change in the Constitution and By-Laws which would have given Negro members active membership status if it had passed. It was voted to continue to give only scientific membership to Negro members.

At the October meeting of the GEORGIA MEDICAL SOCIETY Col. Ralph M. Lechause, USAF (MC), former commander of the Hunter Air Force Base Hospital, spoke on "Thermonuclear Weapons' Effects and Associated Medical Problems in Care of Mass Casualties". Dr. Lechause is at present in the office of the surgeon general, Washington, D. C.

(Societies)

The SUMTER COUNTY MEDICAL SOCIETY had as their speaker at the September meeting in Americus Corbett Thigpen, Augusta. He spoke on "Triple Personalities", and showed a film to illustrate his talk.

The THOMAS-BOOKS MEDICAL ASSOCIATION met on September 26, 1956, at the Archbold Memorial Hospital in Thomasville. The speaker was Corbett H. Thigpen, Augusta, who presented a film on "A Case of Multiple Personality". Election of officers was held at the meeting, and Roy F. Stinson was named to succeed Kirk Shepherd as president. L. M. Shealy, Quitman, was named vice-president, and Julian B. Neel, Thomasville, was elected secretary-treasurer. The next meeting is slated for December 13th in Thomasville.

Arthur J. Merrill, Atlanta, addressed the members of the WARE COUNTY MEDICAL SOCIETY at their meeting in September. His subject was "Nephrosis". Dr. Merrill, who is associate professor of medicine at Emory University, was introduced by Arthur M. Knight, Jr., Waycross.

PERSONALS

Governor Marvin Griffin has sworn in four new members of the State Board of Health. They are ALEX LITTLE, JR., Valdosta; A. M. PHILLIPS, Macon; MAURICE F. ARNOLD, Hawkinsville, and FRED H. SIMONTON. Each of the members is in for a six-year term. Dr. Simonton is the new chairman of the Board of Health.

New officers of the Georgia Heart Association are ERNEST F. WAHL, Thomasville, who was elected president at the Eighth Annual Meeting held in Savannah on September 13th and 14th; J. GORDON BAROW, Atlanta, who is director of the Heart Disease Control Program of the State Health Department, is the new vice-president; A. CALHOUN WITTHAM, Augusta, is the secretary; Mr. James D. Robinson, Atlanta, treasurer; and GOODLOE Y. ERWIN, Athens, is president-elect. Eight members were elected to the Board of Directors for three-year terms and one member for a one-year term. They are as follows. ELLISON R. COOK, III, Savannah;

WILLIAM FACKLER, LaGrange; ARTHUR M. KNIGHT, JR., Waycross; JOSEPH C. MASSEE and BRUNSWICK A. BAGDON, Atlanta; Miss Lucy Harris, Winder; Col. William T. Johnson, Dalton; GEORGE WALKER, Griffin; and Mr. Elfred S. Papy, Atlanta, past chairman of the Board. Nearly 400 physicians, volunteer workers, and others interested in the Heart Association attended the meeting.

Eight Georgia physicians will serve as chairmen of various sessions or present scientific papers at the Annual Meeting of the American Heart Association October 26-29 at Cincinnati. Named to serve as chairmen are: ARTHUR J. MERRILL, Atlanta; EUGENE B. FERRIS, Atlanta, and THOMAS FINDLEY, Augusta. Presenting scientific papers are NOBLE O. FOWLER, WALTER L. BLOOM, JOHN A. WARD, ROBERT H. FRANCH and EDWARD R. DUCHESNE, all of Atlanta. Representing the Georgia Heart Association as delegates to the American Heart Association Assembly are GOODLOE Y. ERWIN, Athens; HARRY T. HARPER, Augusta; JOSEPH C. MASSEE and PURCELL ROBERTS, Atlanta; ERNEST F. WAHL, Thomasville, and A. CALHOUN WITTHAM, Augusta.

Physicians named to serve on the newly organized state nuclear energy advisory commission by Governor Marvin Griffin are R. BRUCE SCHAEFER, Toccoa; T. F. SELLERS, Atlanta; EDGAR R. PUND, Augusta, and GRADY N. COKER, Canton.

Georgia physicians participating in the Golden Anniversary Meeting of the Southern Medical Association, November 12-15, 1956, are as follows: BRIT B. GAY, JR., and JOSEPH CHANG, Emory University, presenting an exhibit in radiology; W. S. FLANAGIN, Augusta, presenting an exhibit in plastic surgery; ALBERT A. BRUST, Atlanta, speaking on "Hypertensive Retinopathy as Revealed by Serial Color Photographs"; JOHN K. BURNS, Gainesville, and JOHN R. MCCAIN, Atlanta, speaking on "Maternal Complications in the Delivery of Infants with Congenital Malformations"; J. HIRAM KITE, Atlanta, speaking on "Syndactylism"; F. JAMES FUNK, JR., Atlanta, speak-

ing on "Hereditary Spastic Paraplegia"; ROBERT L. BENNETT, Warm Springs, speaking on "Orthopedic Devices for Upper Extremity Weakness"; EDGAR BOLING, Atlanta, speaking on "The Role of a Specialty—Proctology"; J. D. MARTIN, JR., Emory University, speaking on "Multiple Abdominal Injuries Due to Nonpenetrating Trauma"; HELEN A. MOORE, Atlanta, speaking on "An Epidemiologic Analysis of Diphtheria Cases"; ROBERT J. RINKER, Augusta, speaking on "Management of Physiological Nocturnal Enuresis"; and MILTON F. BRYANT, JAMES A. KAUFMAN, MAJOR F. FOWLER, and ARTHUR R. EVANS, Atlanta, speaking on "Acute Occlusions in the Renal Vascular Pedicle".

At the recent Tri-State Obstetric-Pediatric Seminar held in Daytona Beach, Fla., there were 340 people registered which makes this year's meeting the largest ever. Attending from Georgia were H. T. ADKINS, Waycross; R. C. BARNES, Byron; HELEN BELLHOUSE, Atlanta; JOHN L. BOWEN, Carrollton; EDMUND A. BRANNEN, Macon; WEDFORD W. BROWN, Athens; STEWART D. BROWN, Royston; M. D. BRYANT, Savannah; LOUIS G. CACCHIOLI, Hartwell; C. WALTER COOLIDGE, Atlanta; ABE J. DAVIS, Augusta; C. H. DICKENS, Madison; JAMES C. DISMUKE, JR., Adel; T. SCHLEY GATEWOOD, Americus; DANIEL H. G. GLOVER, Jesup; EDWIN M. GRIFFIN, Bainbridge; W. E. HARDIN, Waycross; J. T. HOLT, Baxley; FRANK M. HOUSER, Macon; ALBERT R. HOWARD, Jesup; CECIL F. JACOBS, Savannah; HUBERT U. KING, Statesboro; WILBUR D. LUNDQUIST, Savannah; W. C. McCARVER, JR., Gainesville; R. J. MINCEY, Thomaston; HARRY MIXSON, Valdosta; BEN NALLEY, Gainesville; JESSE L. PARROTT, Hahira; ELIZABETH PEABODY, Atlanta; JOHN J. PILCHER, Wrens; M. D. PITTARD, Toccoa; ROBERT A. SMITH, Valdosta; RICHARD L. SMITH, Cochran; ROBERT L. STUMP, Valdosta; JAMES R. THOMAS, Griffin; V. C. WADE, Valdosta; C. H. WATSON, Augusta, and L. C. YEARGIN, Dalton.

Emory University Medical School was among the 15 Southern schools

(Personals)

to receive a grant recently from the Ford Foundation. The grant was for \$500,000.

First District

JOSEPH BONIFACE, Savannah, has been appointed instructor in the department of anesthesiology at the Medical College of Georgia, Augusta. Dr. Boniface received his B.S. degree from Spring Hill College and his M.D. degree from the Medical College of South Carolina in 1946. In 1951 he received his master's degree in pharmacology from the Medical College of South Carolina and since his graduation has been taking post graduate training in anesthesiology and pharmacology at Roper Hospital, Charleston, S. C., and at North Carolina Memorial Hospital, Chapel Hill, N. C.

MILTON MAZO, Savannah, announces the association with him in the practice of pediatrics of CARL H. BRENNAN. A graduate of Cornell University Medical College, Dr. Brennan was a member of the Johns Hopkins Medical School faculty before coming to Savannah. He is a native of Bangor, Me., and is married to the former Miss Mary E. Prendergast of Savannah.

JOHN A. DUNCAN announces the opening of his office in Glenwood for the practice of medicine and surgery.

LEONARD C. DURRENCE, Blackshear, has begun his practice of medicine in the Blackshear Clinic. A native of Claxton, he is a graduate of the Blackshear high school and taught in the Blackshear schools before graduating from the Medical College of Georgia in 1954. He interned at the Athens General Hospital; he also practiced for a short time at the Georgia State Hospital in Milledgeville.

JAMES PATRICK EVANS, Savannah, announces the opening of his office at 301 38th Street, East, for the practice of pediatrics. He is a graduate of the University of Georgia and the Medical College of Georgia. He interned at St. Mary's Hospital in Athens and was resident physician in pediatrics at University Hospital in Augusta. He has been in pediatric service at the U.S. Army Hospital in Frankfurt, Germany, for the past two years.

JOSEPH A. HEFFERNAN, JR.,

Savannah, announces the opening of an office for the general practice of medicine at 14 Jones Street, West. A native of Savannah, Dr. Heffernan is a graduate of the University of Georgia and the Medical College of Georgia. He interned at Mercy Hospital, Buffalo, N. Y., and took further training in cardiology at Georgetown University Hospital, Washington, D. C. Dr. and Mrs. Heffernan, the former Miss Jean Stalvey of Savannah, and their three children reside at 43 57th Street, East, Savannah.

W. D. LUNDQUIST, Savannah, is the new President of the Georgia Tuberculosis Association, having been elected to this office at the meeting of the association held in Rome in September.

JOHN C. WITHINGTON, Savannah, has been promoted to the rank of major in the National Guard and given command of the medical detachment of the 48th Armored Division Artillery, it has been announced. Dr. Withington succeeds RICHARD L. SCHLEY, JR., Savannah, who has assumed his duties as division surgeon on the staff of Maj. Gen. Patrick E. Seawright.

Second District

J. C. BRIM, Pelham, has announced that the Pelham Clinic is now in new quarters on Hand Avenue in Pelham. The building has only recently been completed, and it contains a lab, reception rooms, x-ray rooms, several baths, and treatment rooms.

C. W. HARWELL, Camilla, local commissioner of health and senior surgeon in the USPHS Corps Reserve, recently attended a session of the Civil Defense School in Washington, D. C. He studied medical and hospital care for injured, radiation and chemical warfare, improvised housing, hospital mass feeding, water supplies, and sewage disposal systems.

A portrait of T. C. JEFFORD, Sylvester, has been presented to the Worth County Hospital by members of the Jefford family, at the request of the Hospital Authority made in 1950. Dr. Jefford himself requested that the portrait be placed by the nursery because of his "hope and belief that the future generations of Sylvester and Worth County will carry on the good works of this fine

institution". Julia Ann Jefford, the doctor's great niece, unveiled the portrait which was presented by Mrs. L. H. Herrin, his sister.

JOHN A. MEIER, Albany, announces the opening of his office at Third Avenue and Jefferson Street for the practice of orthopedic surgery. Dr. Meier is a graduate of the University of Nebraska College of Medicine. He interned at the University of Indiana and served two years in the Navy as a medical officer. Dr. Meier was engaged in general practice in Nebraska for three years.

ROBLEY D. SMITH, III, Tifton, announces the opening of his office for the general practice of medicine in Tifton. A native Georgian, Dr. Smith is a graduate of the University of Georgia and the Medical College of Georgia. He interned at Walter Reed Hospital, Washington, D. C., and subsequently served as flight surgeon in the Air Force for two years before entering private practice in Tifton.

L. W. WILLIS, Bainbridge, was surprised on his birthday, August 20th, with a huge cake baked in the Decatur County Prison and presented by the prisoners, for whom Dr. Willis acts as physician. The great mystery is how they found out when his birthday was, but the huge cake was iced in white and embossed with colored roses and the greeting, "Happy Birthday to Dr. Willis."

Third District

ROBERT H. VAUGHAN, Columbus, has been elected secretary-treasurer of the Georgia Trudeau Society.

Fourth District

ENOCH CALLAWAY, LaGrange, directed symposia in Albany and Dublin in August to discuss with physicians the latest developments in detecting and treating cancer. Dr. Callaway is director of professional education of the Georgia division of the American Cancer Society. Visiting physicians who conducted the sessions were W. H. Clark, Jr., New Orleans; Jack Pigott, Memphis; and Neal Owens, New Orleans.

J. WELDON KELLY, Griffin, announces the removal of his office to 415 South 8th Street for the practice of general surgery.

(Personals)

WELLS RILEY, Jonesboro, has been elected president of the Jonesboro Junior Chamber of Commerce. Dr. Riley is a native of Johnston, S. C., and has been practicing in Jonesboro since December 1954.

ROBERT M. WEST, Franklin, was elected president-elect of the Southern Endocrine Society at the convention held recently in Augusta.

Mrs. Virginia Parker and CHARLES OLIN WILLIAMS, West Point, were married at the home of the bride on August 18, 1956. Dr. Williams is a Life Member of the Medical Association of Georgia and has practiced general medicine and surgery in West Point for quite a few years.

Fifth District

The Chamber of Commerce of East Point recently honored eight new physicians in the area at a meeting of the Merchants Division of the East Point Chamber of Commerce. Doctors invited to the meeting were LEWIS B. HASTY, JOHN E. ALLEN, HUGH GEIGER, CECIL PIRKLE, NOMAN BLASS, R. E. ROBERTS, ALBERT A. RAYLE, and J. FRANK WALKER.

JOHN E. ALLEN, JR., East Point, has opened his office for the practice of pediatrics in East Point. Dr. Allen is a native of East Point and a graduate of Russell High School, Emory University, and the Medical College of Georgia.

JOHN F. BERTLES, Atlanta, has been appointed a research fellow in medicine at Harvard Medical School. Dr. Bertles will be associated with Massachusetts General Hospital in Boston. Dr. Bertles is a graduate of Yale University and Harvard Medical School, class of 1952.

WINSTON E. BURDINE, Atlanta, who has long been active in veterans affairs, was elected national vice-commander of the Amvets, Veterans of World War II, at the national convention held in Milwaukee on September 2nd.

ALLEN M. COLLINSWORTH, Atlanta, recently elected director of the Industrial Medical Association, has been appointed junior director of the Committee on Public Relations. He has served as Counselor for

Georgia and Florida since 1950 and is now serving as Regional Consultant for the Occupational Health Institute, an educational and certifying affiliate of the Industrial Health Association.

JOHN D. CAMPBELL, Atlanta, spoke to the Atlanta Writers' Club on "Psychiatry and Literature" at a meeting held on September 20th.

One of the speakers at the first orientation meeting for training Big Sisters for The Big Sister Association, Inc., was LEILA DENMARK, Atlanta, who is also a consultant for the association. The Big Sister program provides individual support to the emotional, spiritual, and moral needs of girls through the understanding friendship of a mature adult and is an outgrowth of the Atlanta Girls' Club.

NOBLE O. FOWLER, Atlanta, was a guest speaker at the Eighth Annual Meeting and Scientific Sessions of the Georgia Heart Association held in Savannah on September 14-15, 1956. The title of his talk was "Pulmonary Hypertension—A Common Occurrence in the Heart and Lungs".

J. R. S. HIMEBAUGH, Atlanta, announces the opening of his office at the Sandy Springs Shopping Plaza for the practice of general medicine. Dr. Himebaugh has been practicing in Indiana for the past 14 years.

At the recent meeting of the Southeastern Allergy Association held on October 5 and 6 at the Barringer Hotel, Charlotte, N. C., LEWIS D. HOPPE, Atlanta, was moderator for a panel discussion on Pediatric Allergy. WILLIAM A. HOPKINS, Atlanta, spoke on "Surgical Treatment of Chronic Lung Diseases Which Cause Asthma; Bronchoscopy, Excision of Tumors, Lobes, Cysts, Nerve Resection," etc. OLIN SHIVERS, also of Atlanta, spoke on "Psychiatric Aspects of Allergy in Pediatrics".

Dr. and Mrs. A. H. LETTON, Atlanta, attended the meeting of the International College of Surgeons held in Chicago in September. Dr. Letton took part in a symposium on Thyroid Disease and attended the meeting of the Board of Regents.

JACK C. NORRIS, Atlanta, was chairman of the Fulton Democratic Stevenson Committee. The unit was

part of the official fund-raising network which the state Democratic Committee set up all over the state.

After spending two years in Boston, Dr. and Mrs. HARRISON REEVES and their children, Nancy and Susan, have returned to Atlanta to live and practice medicine.

PAUL L. SCHROEDER, Atlanta, presented a series of lectures at the Veterans Administration Hospital as a part of the educational program for the professional staff of the hospital. Dr. Schroeder lectures on "Growth and Development of Personality" and "The Role of the Physician in the Treatment of Children with Behavior Problems". Dr. Schroeder is a native of Illinois and a graduate of the University of Illinois College of Medicine. Before coming to Atlanta he was Chief of Psychiatry of St. Joseph's Hospital in Chicago. He is at present clinical professor of child psychiatry at Emory University.

CARL A. WHITAKER, Atlanta, also presented a series of lectures at the VA Hospital in Augusta. He spoke on "Growth of the Therapist" and "The Development of Group Psychotherapy". Dr. Whitaker is a native of New York and is at present engaged in the private practice of psychiatry in Atlanta.

Sixth District

BRASWELL COLLINS, Macon, is now limiting his practice to ophthalmology.

LOUIS L. HATCHER, Dublin, had a narrow escape when the motor of the boat from which he and his brother were fishing went dead in the Gulf of Mexico. Resourcefully rigging their raincoats as sails, they made their way across 20 miles of the squally Gulf to safety.

WILLIAM S. HELTON, Sandersville, reopened his office on East McCarty Street, September 1, 1956, after two years' active duty with the U.S. Navy. On September 13th he was married to the former Miss Evelyn Roberts of Jacksonville, Fla., at the Folkston Methodist Church, Folkston, Ga. Dr. Helton is a graduate of the Medical College of Georgia and interned at Jackson Memorial Hospital, Miami, Fla. He is the son of B. L. HELTON, who has practiced medicine in Sandersville for the past 30 years.

(Personals)

MALCOLM HODGES, Macon, announces the removal of his office to 3266 Pio Nona Avenue next to Faile's Pharmacy.

LON KING, JR., Macon, and his family have moved into their new house at 2789 Sheffield Road, Macon.

LEON D. PORCH, Macon, has retired from the active practice of medicine it has been announced.

DAVID E. QUINN, Dublin, has named a state director-at-large of the Georgia Tuberculosis Association at the meeting held in September. He was also made a member of the Georgia Trudeau Society.

Seventh District

JOHN H. GROSS, Rome, was elected president-elect of the Georgia Trudeau Society at the annual meeting held in Rome in September.

JOHN W. LOOPER, JR., Dalton, announces the opening of his office at 200 West Waugh Street, Dalton, for the practice of pediatrics. Dr. and Mrs. Looper are both natives of Dalton. Dr. Looper is a graduate of Emory at Oxford and Emory University. He received his M.D. degree from the Medical College of Georgia in 1952. The Loopers have spent the past four years in Baltimore where he was associated with the University of Maryland School of Medicine.

Eighth District

E. G. BELL, Douglas, will return to his practice the first of the year. Dr. Bell is now taking a course in surgery at the University of Indiana which he will complete in December. Mrs. Bell and their children have already returned to their home on Ocilla Road.

WILLIAM F. AUSTIN, formerly of Blackshear, has opened an office for the practice of medicine in Brunswick. He was formerly associated with the Blackshear Clinic.

JOSEPH L. McCRARY, Jesup, attended the postgraduate lectures on endocrinology given in Atlanta on August 24 and 25.

Ninth District

RAFE BANKS, Gainesville, was

the speaker at the meeting of the Jackson County Unit of the American Cancer Society on September 27th. Dr. Banks is a member of the Georgia State Board of the Cancer Society and a member of the staff of the Hall County Hospital and Clinic.

WILBUR BAUGH, Gordon, has opened offices at the Gordon Legion Hall for the practice of medicine. Dr. Baugh is a native of Baldwin County and is married to the former Miss Joan Bentley of Wilkinson County. They are at present residing in a trailer on the grounds of Legion Hall.

Dr. and Mrs. E. H. ETHERIDGE, formerly of Winder, visited in Winder recently. Dr. Etheridge is on active duty with the U.S. Navy and expects to complete his tour of duty early in 1957, at which time he will return to Winder and resume his practice.

GEORGE M. TOLHURST, Cleveland, is leaving after seven years' service to the people of White County to serve as a medical missionary for the Seventh Day Adventist Church in Okinawa. Dr. Tolhurst said that the assignment is the fulfillment of a long-time ambition. A native of Atlanta, Dr. Tolhurst is a graduate of Southern Missionary College, Collegedale, Tenn., and the College of Medical Evangelists, Loma Linda, Calif. Dr. Tolhurst's replacement in Cleveland will be DONALD FAHRBACK, formerly of Spartanburg, S. C., and also a graduate of the College of Medical Evangelists.

J. G. WOODWARD, Dahlonga, announces the association with him in the practice of medicine of GEORGE D. GOWDER, JR., formerly of Gainesville. Dr. Gowder is a graduate of North Georgia College and the Medical College of Georgia.

Tenth District

WILLIAM E. BARFIELD, Augusta, presented two papers at the annual meeting of the Texas Academy of General Practice held in September. Titles of the papers are "Experience with Autonomic Depressant Drugs, Placebos, and Steroid Medication in Management of Climacteric" and "Diagnosis and Management of Threatened and Habitual Abortions". Dr. Barfield is assistant clinical professor of en-

docrinology at the Medical College of Georgia.

HARRY L. CHEVES, SR., Union Point, has been made a qualified fellow of the International College of Surgeons. Dr. Cheves went to Chicago to receive his certificate of fellowship at the annual meeting of the college in September. Dr. Cheves is a former president of the Wilkes County Medical Society, the Georgia Academy of General Practice, and has served for many years as Councilor from the Tenth District, to the Medical Association of Georgia. He is at present one of the two delegates from Georgia to the National Convention of the American Academy of General Practice, and he is president of the Union Point Chamber of Commerce.

Dr. and Mrs. CHARLES DICKENS, Madison, attended the annual Tri-State Postgraduate Obstetric and Pediatric Seminar held in September in Daytona Beach, Fla. On their way home they visited their children, Dr. and Mrs. R. G. Connar and Dr. and Mrs. Charles Dickens, Jr.

The *Journal* regrets to announce the death on September 8, 1956, of Mrs. Helen Dula Hamilton, wife of WILLIAM F. HAMILTON, SR., and mother of WILLIAM R. HAMILTON, JR., Augusta.

DILLARD NIX, formerly of Commerce, announces the opening of his offices at 1010 Prince Avenue, Athens, in association with A. P. KELLER, JR., and J. C. HOWARD. Dr. Nix is an eye, ear, nose, and throat specialist. He is a graduate of the University of Georgia and the Medical College of Georgia. He interned at Georgia Baptist, Atlanta, and took his residency training at the VA Hospital in Atlanta. While in the Armed Forces Dr. Nix served as a major and chief of the EENT department at William Beaumont Army General Hospital in El Paso, Texas.

W. A. RISTEEN, Augusta, has been recalled to active duty with the U.S. Navy. He will be stationed at the U. S. Naval Hospital at Camp Pendleton, Calif., for an indefinite time.

DAVID THOMAS, of Augusta, spoke on "Drug Allergy" at the meeting of the Southeastern Allergy Association held in Charlotte, N. C., in October.

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Journal OF THE MEDICAL ASSOCIATION OF GEORGIA

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COVER

This month's cover is by Ted F. Leigh, M.D., and symbolizes Secretory Otitis Media—see also page 499.

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Recommendations of the Hospital Care Study Commission

(Listed below are the recommendations of the Hospital Care Study Commission, approved at a final meeting, Sunday, November 25. The Commission, set up by the Georgia General Assembly, began work in June to determine the extent of hospital care for the state's indigent and medically indigent and to recommend ways and means of more adequately providing such care. Following an official report to Governor Marvin Griffin, it is expected that legislation will be prepared to carry out the recommendations. Membership of the Commission includes three physician representatives from the Medical Association of Georgia, as well as representatives from the Georgia Hospital Association, the Georgia Association of Hospital Governing Boards, the Georgia Association of County Commissioners, the directors of the State Department of Public Health and the State Department of Public Welfare.)

I. The Commission makes the following general recommendations:

(1) The State of Georgia should assume some responsibility for assisting local communities in providing adequate hospital care to all indigent sick and injured in the State.

(2) The General Assembly of Georgia should establish a program for indigent hospitalization and appropriate funds on a matching basis to encourage counties and cities to assume more adequate responsibility locally for hospital care of the indigent.

(3) The program should be planned on the assumption that the medical profession will continue to provide the medical services need of indigent patients while in the hospital, without charge, pending further study.

(4) The program should have state-wide application and compensation to hospitals should be without profit to the hospital and in line with actual cost of services rendered.

(5) The program should provide for tax funds to cross county lines and follow indigent patients wherever they may be hospitalized.

(6) The program instituted should not replace existing federal, state, and local programs for the indigent but rather should supplement and make fuller utilization of present programs (vocational rehabilitation, cancer, crippled children, child welfare, Alcoholic Commission, Battery tuberculosis hospital, Eugene Talmadge Memorial, Milledgeville State, and the like.)

(7) The proposed program should make broad provision for financial contributions from as many different groups (official and voluntary agencies) in-

cluding federal, state, county, and city payments to assist individuals to purchase care without undue financial burden to the individual or any one political sub-division.

(8) The proposed programs should discourage over-utilization of expensive hospital facilities, by encouraging shorter length of stays in expensive facilities and the transfer of patients to facilities providing the level of care required (out-patient services, home nursing supervision, nursing home care, and chronic or convalescent hospital units).

(9) The proposed legislation should be primarily enabling legislation, with minimum restrictions with the exact details of administration to be worked out by the administrative agency and the advisory council to be established for this purpose.

(10) The program should be administered locally, as far as possible with minimum state regulations and with the medical and the financial need of patients determined locally.

(11) The program should be started on a *small* scale with adequate provision for future expansion based on experience and need.

(12) The program should provide from each co-operating county, a required minimum contribution (per capita amount) and a maximum (per capita) that the state may contribute, with such determination to be based on the amount of state matching funds available.

(13) The program should assure the taxpayer that expenditures of tax dollars will be of maximum benefit, not only to those who receive the service but to those who pay for the service of others.

II. The Commission makes the following specific recommendations:

(1) That the program established should include the medically indigent (non-welfare patients) as well as the indigent (welfare patients) with special emphasis on short-term acute (stays of less than 30 days) illnesses.

(2) That due to the acute problem of the chronically ill, it is recommended that the welfare department and other agencies give special and immediate attention to supplementing welfare patients in need of nursing home care.

Hospital Care Commission (cont'd)

(3) That a State Hospital Care Council be established to advise the administration of the program. The Council is to consist of thirteen (13) members, with two to be selected by the Medical Association of Georgia, two by the Georgia Hospital Association, two by the Association of County Commissioners, two by the Georgia Association of Hospital Governing Boards, the Director of State Department of Public Health, the Director of the State Department of Public Welfare and three by the governor from the state at large.

(4) The program should be administered as far as possible locally with minimum state regulations with the medical need and the financial need of patients determined locally.

(5) The program should be started on a *small* scale with adequate provision for future expansion based on experience and need.

(6) The initial program should provide for a 50c per capita appropriation by the State (about \$1,-800,000) to be matched by the cooperating counties:

(7) *The Matching Formula:*

- (a) The State will match 75% the first \$5,000 of total cost.
- (b) The second \$5,000 cost State would match 50%.
- (c) The third \$5,000 and all up to the maximum additional cost State would match 25%.
- (d) The State will match a budget that exceeds up to but not exceed a budget of \$1.00 per capita.
- (e) Counties will give priority to payment for care for local residents indigent patients that cross county lines for hospitalization.

(8) The local share to be provided by counties should be equalized, based on the total amount of funds that are required for a minimum county program. The budget for each county shall equal the population of the county multiplied by the per capita level of state funds available annually for the program.

(9) The extent of reimbursement of hospitals will depend on funds made available annually for such purpose.

(10) Financial eligibility determination is to be made locally in accordance with broad state-wide policy. The primary responsibility for this determination will rest with the fiscal authorities of the

county and this activity may be delegated by them to other agencies within the county.

(11) The medical and the financial needs of the patient should be determined and administered locally as far as possible, with minimum state regulations.

(12) The Plan will apply only to licensed hospitals with a licensed doctor of medicine as chief of staff.

(13) That for a county to qualify for participation in the program, the following must be complied with: (a) A resolution by local county commissioners (taxing authorities) that the county wishes to participate in the program; (b) establish a local budget for such purposes (that includes both local and state shares); (c) appoint a local administrative agency according to instructions; (d) appropriate at least the minimum per capita amount to cover the local share of the established budget for hospitalization.

(14) A small administrative agency be established under authority of the State Board of Health, with the new unit to delegate by negotiations, any specific function that may be performed by other state agencies. This will tend to result in cooperation and lower administrative costs.

(15) The agency responsible for the administration of the program should be authorized to aid local communities to solve or alleviate the problem of indigent hospital care by means other than direct financial assistance. Such activities may include publishing of statistics on the program, information, research and or guidance to local communities in decreasing hospital costs and/or methods for the extension of prepaid hospitalization coverage to farm and low-income groups.

(16) If any county does not desire to participate in the program, state funds for that county will be reallocated after a reasonable period, to other participating counties.

(17) State funds should aid those counties now fulfilling their community obligations, as well as those counties that are unable or unwilling to care for the hospitalization of the indigent.

(18) The program should be administered to provide hospital care for the citizens who are sick and injured and who can benefit from definitive treatment in a hospital, but who are unable to meet the cost from their own resources or from resources of those upon whom they are legally dependent. The program shall not care for citizens who are already cared for by special programs of the state and local agencies.

Journal OF THE MEDICAL ASSOCIATION OF GEORGIA

Chronic Secretory Otitis Media: Etiology, Diagnosis and Treatment

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SECRETORY OTITIS MEDIA is the most common cause of hearing loss in children and is therefore a condition that we must be able to recognize early and treat adequately if we are to prevent chronic adhesive otitis media with its resultant permanent hearing impairment.

The purpose of this paper is to discuss the possible reasons for the increasing frequency, particularly in children; to review the various causes of chronic secretory otitis media; and to examine our results in the treatment of the chronic cases in children by adenoidectomy and by external irradiation.

The term secretory or serous otitis media is intended to include the condition of all patients who have an accumulation of serous or mucus (non-purulent fluid in the middle ear and usually the mastoid cavity as well.

Actually, when we speak of the "middle ear" we mean the tympanic cavity, the Eustachian tube, and the mastoid cavity. These structures are vestiges of the old first gill pouch, and embryologically the Eustachian tube is a diverticulum of the nasopharynx.

Pathogenesis

The first questions to concern us might well be, "Why does this fluid collect in the middle ear and how does it get there?"

Sterile fluid in the middle ear may occur as the result of one or both of two pathological processes:

The primary pathology is usually a blocked Eustachian tube. This creates a vacuum in the middle ear, and the action of the negative pressure on the thin-walled arterioles and capillaries of the mucosa results in transudation of fluid elements of the blood serum into the middle ear spaces. Transudation due to a vacuum alone occurs in its purest form in aer-otitis media.

Secondly, the fluid may occur as a response to low-grade (hypo-virulent) inflammatory reaction in the mucosa of the Eustachian tube and tympanum, secondary to an upper respiratory infection, in which

case the fluid is an exudate, but sterile by ordinary culture methods.

The pathogenesis of this condition is undoubtedly influenced by the anatomical and histologic structure of the Eustachian tube and tympanic cavity, and by the histologic changes that occur in the presence of low-grade inflammation as shown by the work of Eggston and Wolff.¹ The possible influence of these factors has been discussed in an earlier paper by the author² and need not be repeated in detail here.

The following variations, however, may explain why some middle ears develop an effusion and others do not under similar conditions:

1. Variations in the size of the Eustachian tube isthmus in individuals of the same age.
2. Variability in thickness of the mucosa covering the arterioles in the tympanic cavity.
3. Differences in capillary permeability.
4. Differences in the function of the muscles governing the Eustachian tube orifice (tensor veli palatini.)

Incidence

Secretory otitis media is being recognized with increasing frequency all over the country. This is in part due to the increased awareness by otologists and pediatricians of the possibility of its presence but I believe there is little doubt that there has also been an actual increase in its incidence.

One of the chief reasons for the actual increase is to be found in the fact that we are seeing more and more hypovirulent, but insidious, infections due to the increased use of chemotherapy and antibiotics. Goodale³ has observed that the antibiotics arrest the infection in the nose and throat to a certain extent but do not relieve the fluid trapped by the obstructed Eustachian tubes. Therefore what originally was a bacterial disease in the nasopharynx and Eustachian tube, and in pre-antibiotic days would probably have led to a suppurative otitis media, ends up now as a sterile otitis.

Eagle⁴ and others are of the opinion that many of these cases are due to viral infections and some of

Presented at the 106th Annual Session of the Medical Association of Georgia, Atlanta, May 13-16, 1956.

them probably are. However, up to the present time no one has been able to find a virus in the fluid. Robison and Nicholas⁵ injected fluid from 17 cases into white mice of a strain susceptible to virus diseases, and they all remained well. They also made cultures into embryonated eggs with similar material, and no growth was obtained. Harcourt and Brown⁶ subjected the fluid from a number of cases of serous otitis media for study at the Army Research Laboratory for Virus and Rickettsial diseases, with negative findings.

Increased air travel accounts for a small part of the increased incidence, but this factor is negligible in the average otologist's daily practice.

Influence of Climate

The largest number of cases of secretory otitis media are seen in months of extremely variable temperature, because these are the months during which upper respiratory infections are most prevalent. In my part of the country this happens to be in February, March, and April when it is common to have as much as 30 - 35 degrees difference between the low and high temperature in a 24-hour period, the maximum change occurring during the night when an individual may be inadequately covered and become chilled.

Altitude and humidity apparently influence the incidence of this disease also. In 1951, the author² conducted a nation-wide survey and found that secretory otitis media is seen much more commonly in regions of low altitude and high relative humidity. An individual with pre-existing pathology in the Eustachian tube is apparently less likely to develop tubal obstruction and effusion in a high dry climate than in a moist climate at or near sea level.

Influence of Age

Secretory otitis media can occur at any age, but in my experience it is most prevalent in children under 10 years of age. Forty-three per cent of the patients in my total series of 781 cases were in that age group. There are several pertinent reasons for this:

1. Recurrent upper respiratory infections are more frequent in young children.

2. Hypertrophied adenoids are the chief predisposing factor.

3. We were formerly taught that the Eustachian tube orifice of a child was relatively larger than in the adult, but Tremble⁷ on the basis of a large number of anatomical dissections, has shown that the reverse is true.

4. Allergy is an important factor in children not only because it may produce edema of the tube, but because allergic children have the greatest lymphoid hypertrophy.

5. Many of these children with secretory otitis

media are being discovered by school hearing surveys because their only symptom is impaired hearing.

Etiology

I. As we have stated in the preceding discussion, the most important factor in the etiology of this disease is an obstructed Eustachian tube. Any condition which is capable of producing swelling of the tubal mucosa, compression of the ostium or lumen of the tube, or in any way interfering with normal tubal function must be considered a possible etiologic factor.

1. Conditions which may cause swelling of the mucosa of the Eustachian tube are acute upper respiratory infections, acute and chronic sinusitis, chronic nasopharyngitis, allergy and less commonly, swimming.

2. Compression of the ostium or lumen of the tube:

- (a) Hypertrophied adenoids and lateral pharyngeal folds—Although enlarged adenoids probably rarely actually grow over the Eustachian orifice, they undoubtedly promote compression of the ostium during an acute nasopharyngitis or adenoiditis either directly or secondarily by pressure on the tube from an enlarged lateral retropharyngeal lymph node. Furthermore, adenoids which obstruct the posterior choanae prevent a normal flow of air from reaching the Eustachian orifice. I find myself in agreement with Lindsay⁸ who states, "The incidence of chronic secretory otitis seems to have been increased by the swing of the pendulum toward extreme conservatism in recommending removal of adenoids and tonsils, a tendency resulting partly from the sense of security afforded by antibiotic therapy."

- (b) Malignancy of nasopharynx — Serous otitis media is often the first sign or symptom of carcinoma of the nasopharynx, being first unilateral and later bilateral. Harcourt and Brown⁶ reported observing serous otitis media in seven of the 12 cases of nasopharyngeal malignant tumor encountered at Walter Reed Hospital over a five-year period. Fluid was present in the middle ear for periods varying from four months to two years before a positive biopsy could be obtained.

- (c) Enlarged lateral retropharyngeal lymph nodes — The lateral retropharyngeal lymph nodes receive lymph from the sinuses, nasopharynx, and middle ear, and enlargement of these nodes may compress the membranous portion of the tube near its pharyngeal end. Robison⁵ is of the opinion that this is probably the most common cause of tubal obstruction. The nodes may be enlarged as a result of in-

fection or malignancy in the sinuses or nasopharynx, or as a result of Hodgkin's disease or leukemia.

(d) Malocclusion — The membranous portion of the tube may be compressed by the external pterygoid muscle. Malocclusion will be discussed in more detail under another heading.

3. Interference with normal tubal function:

(a) Aerotitis media is an example of effusion into the tympanic cavity, occurring when the Eustachian tube function cannot keep pace with the rapidly changing atmospheric pressure on the other side of the drum. Armstrong⁹ found that in descent, a differential of 90 mm. pressure will "lock" the orifices of the Eustachian tube due to its flutter-valve action, in such a manner that the act of swallowing will no longer open it.

(b) Children with cleft palates, even though they have been expertly repaired, are prone to have serous otitis media. This can be explained by the fact that the tensor veli palatini muscle, generally credited with the function of opening the Eustachian tube, is normally inserted in an aponeurosis in the center of the soft palate where it meets the fibres of its mate of the opposite side. In the case of cleft palate, the function of this muscle is likely to be impaired.

(c) Malocclusion—In my opinion, malocclusion is an important cause of recurrent and chronic serous otitis media in individuals who have lost molar teeth and in older patients who have poorly fitting dentures or who refuse to wear their dentures. Costen's hypothesis¹⁰ was that closing of the bite causes compression of the membranous part of the Eustachian tube by a "wrinkling-up" of the external pterygoid muscle. Overclosure or malposition of the jaw also shortens the span of the tensor veli palatini muscle and renders its action ineffective in opening the tube. Malocclusion may predispose to serous otitis media in one or more other ways also. Kelly and Langheinz¹¹ and Bierman and Brickman¹² believe that malocclusion interferes with normal lymphatic drainage of the tube. The latter authors found aerotitis media to occur three to five times as frequently in air corps trainees with malocclusion as in their control group with normal occlusion. Furthermore, the incidence of aerotitis media in the group with malocclusion was markedly reduced by the use of splints which corrected the intermaxillary distance. Seaver¹³ believes that malocclusion decreases the chewing action and inhibits swallowing reflexes which in turn affect the tubal muscles.

(d) Paralysis of the tensor veli palatini muscle (supplied by a branch of the fifth nerve) can occur in bulbar poliomyelitis, diphtheria, and possibly central lesions, but fortunately these are infrequent causes.

(e) Trauma to the tubal orifice during surgery, or during vigorous repeated catheterizations, or bouginage of the tube are also considered infrequent causes of stenosis. Occasionally a stricture of the tube may be found following a suppurative otitis media and salpingitis.

(f) Senility and debilitated states may result in myasthenia with poor tubal function.

(g) Congenitally small Eustachian tube isthmus. As has been mentioned earlier, Eggston and Wolff have observed that the size of the isthmus of the tube varies considerably in individuals of the same age. If one or both isthmuses are congenitally smaller than average, this fact alone would interfere with normal function of the tube and predispose that individual to secretory otitis media. Although this might serve as a convenient explanation for the chronic cases in which we can find no other cause, the diagnosis of a congenitally small Eustachian tube isthmus cannot be made clinically.

II. There are certain systemic conditions which abnormally affect tissue fluid balance and increase the capillary permeability, thus predisposing the individual to effusion of fluid into the tympanic cavity. These systemic conditions, although rarely the sole primary cause of fluid in the middle ear, predispose to chronicity. Cardiac insufficiency, cardio-vascular renal disease, metabolic and endocrine disturbances, autonomic dysfunction, and physical allergy are included in this category.

Of these, autonomic dysfunction and physical allergy are probably the most important. Arteriolar spasm produces ischemia and anoxia of the tissues lining the tympanic cavity, and the anoxia in turn causes capillary dilatation and transudation or effusion. I have seen several patients with fluid in the middle ear who had other associated signs of autonomic dysfunction or so-called intrinsic allergy as the only apparent cause.

III. Aborted acute or subacute otitis media often results in fluid in the middle ear. I have classified this type of secretory otitis media under a separate heading because the onset is that of an acute inflammatory otitis media rather than being secondary to primary tubal obstruction. However, the end-result is the same.

This type, contrary to primary serous otitis media, usually starts with an earache. If this occurs at night,

antibiotics are often prescribed by telephone; or if the patient is seen by a physician, an injection of penicillin may be given. When the pain and fever subside, the mother often feels that her child doesn't need any further medication. Nothing more is done until sometime later when a hearing impairment is noticed by the parent or school teacher. The hearing impairment, of course, is due to the collection of serous or mucus fluid trapped in the tympanic cavity.

This series of events happens quite often and calls attention to the importance of follow-up examinations when antibiotics are used. If the drum or the hearing does not return to normal after a reasonable period of antibiotics, a myringotomy should be done. An early myringotomy will prevent many of these cases.

Clinical Types of Secretory Otitis Media

There are two clinical types of this condition, serous and mucus. In some patients, one ear may contain serous fluid and the other mucus fluid.

The serous type ear may change to the mucus type or become suppurative during an acute upper respiratory infection; and then as the infection subsides, it may revert back to serous, if the tubal obstruction is chronic.

The serous fluid is a transudate, clear and light yellow in color, usually thin and watery in consistency, but it becomes thicker and tenacious and finally coagulates when exposed to air. It contains few or no inflammatory cells and usually has a low protein content. The protein content, however, increases in chronic cases due to the reabsorption of fluid elements. This type is due to mechanical blockage or dysfunction of the Eustachian tube.

The mucus type is seen most often in children during or after an acute upper respiratory infection. The mucus is a sterile exudate—thick, tenacious, viscid, and often turbid. It contains many inflammatory cells, mostly polys, and it usually has a high protein content.

With regard to the sterility of the fluid in secretory otitis media, bacteria have been found on smears by King¹⁴ and others, but no bacteria have been found on culture. There is a possibility that the fluid itself may inhibit the growth of bacteria, similar to the bacteriostatic properties of the blood serum. Lahikainen¹⁵ has submitted strong evidence favoring this view. The agent causing bacteriostasis, according to Lahikainen, appears to resemble lysozyme and "inhibin."

Symptoms

Adult patients complain chiefly of a "stopped-up" or "full" feeling in the ear, usually of sudden onset. If the middle ear is only partially filled, they may feel fluid moving about or a bubbling sensation upon

sniffing or forcefully blowing the nose. Autophony is a common symptom. Many will say that the ear feels numb or "dead," and there is a sensation of numbness of the skin around the auricle and adjacent scalp. These patients usually have a full tympanum and mastoid cavity. A few patients complain of slight dizziness. A diagnostic symptom, if the middle ear is only partially filled, is the temporary improvement in hearing upon tilting the head toward the affected side or upon lying down, thus permitting the fluid to drain away from the round window.

Young children, on the other hand, do not usually complain of these symptoms and are content to go about with fluid in their middle ears for weeks or months until someone notices that they are not hearing as well as they should.

Diagnosis

The diagnosis of serous otitis media is usually easy if one keeps the condition in mind, but it is still being missed too often. In the majority of cases one can strongly suspect its presence from the history.

Inspection usually reveals the characteristic amber or yellow color imparted to the translucent drum, which is not inflamed and may or may not be retracted. If the drum is opaque, this amber color usually cannot be detected. In long standing cases the drum occasionally has a bluish color, probably due to the congested mucosa on the promontory. Hoople¹⁶ has emphasized the chalk-white appearance of the malleus handle and short process.

If the tympanum is not filled with fluid, one can often see a fluid line or bubbles through the drum, and when these signs are present, the diagnosis is readily apparent; however, a full tympanum is encountered more frequently than the drum with a meniscus.

In the mucus type ear, the drum has a more reddish hue with a dispersed light reflex, i.e., more of a waxy sheen on the surface, and is less transparent.

In doubtful cases, I routinely use the pneumatic otoscope to test the mobility of the drum, and I consider it a valuable aid in diagnosis. When the ear is full of fluid, the drum will move only slightly, but when the drum is freely movable, one will rarely find fluid behind it.

The hearing loss, conductive in type, varies with the amount of fluid present. The tuning fork tests help to confirm the diagnosis. The Rinne will be negative and the Weber test is lateralized to the involved ear or to the ear containing the most fluid. The audiometric "curve" is usually almost flat unless there is a pre-existing nerve deafness.

In children, the whispered voice test is a simple but very helpful procedure that can be employed by anyone without special equipment or training.

The hearing for whispered voice is frequently reduced to 5/15 or even 1/15 when the ear is full of mucus fluid.

In serous ears that are not full, the response to whispered voice may be impaired only slightly.

The next step advocated by many, if one is not certain of the presence of fluid, is the diagnostic inflation using a catheter and diagnostic tube. When the air passes through fluid one can hear a bubbling or "chugging" sound. I am of the opinion that it is preferable to avoid using the Eustachian catheter if possible because of its traumatic effect upon the pharyngeal orifice of the tube and the risk of prolonging the disease.

The author is a firm believer in doing a diagnostic paracentesis if one is not certain of the presence of fluid. This can be done with or without topical anesthesia, with little discomfort to the patient. The paracentesis should be preceded and followed by Politzerization because the fluid will not drain out of a vacuum. As one becomes more familiar with the appearance of the fluid-filled ear, supplemented by the use of the pneumatic otoscope, one will create very few "dry taps."

Having established the presence of an effusion in the ear, one must not forget to make an etiologic diagnosis, for therein lies the difference between a possible cure and a recurring or chronic secretory otitis media.

Prognosis

With regard to prognosis, in the vast majority of cases the hearing returns to normal after the fluid is evacuated, regardless of the number of myringotomies, unless there are adhesive processes or pre-existing inner ear pathology.

There are some ears, as we all know, that continue to refill with fluid, and the reason for this chronicity is either that we have not made a correct etiologic diagnosis and treated it adequately, or that irreversible changes have occurred in the Eustachian tube and tympanic cavity.

When we see the patient for the first time there are certain signs that we may regard as unfavorable; namely, (1) a history of long duration, (2) tenacious glue-like secretion, (3) Eustachian tube difficult or impossible to inflate, (4) etiology not apparent or multiple causes, e.g., children with nasal allergy, lymphoid hypertrophy, and unusual susceptibility to infection, and (5) blue ear drums, indicating long standing involvement.

Treatment

The objectives in the treatment of secretory otitis media are to rid the middle ear of fluid, prevent its recurrence by correcting the underlying cause, and thereby restore and preserve good hearing.

Many cases are of brief duration and may resolve with or without myringotomy after the acute upper respiratory infection has subsided. These obviously offer no problem or challenge. There are many others however that run a protracted course for weeks or months at a time and seem to defy all efforts to bring about a cure. It is the treatment of these recurrent and chronic cases that we shall discuss here.

I. Treat the exciting cause—

In the chronic cases with possible multiple causes, I have found it helpful to make a smear of the fluid for cell count per H. P. F. When the fluid is loaded with inflammatory cells, as the mucus type most often is, although it is sterile, one can be certain that the condition is caused by an inflammatory process. A further search for infection may reveal a previously undiagnosed sinusitis or adenoiditis. An intensive course of antibiotics is then indicated along with the usual local measure. On the other hand, if the fluid contains few or no inflammatory cells, and one can find no infection in the upper respiratory tract, we should direct our thoughts to the possibility of non-inflammatory mechanical blockage of the tube, such as may be caused by allergy, malocclusion, neoplasm of the nasopharynx, Hodgkin's disease, etc.

Children and adults who have repeated upper respiratory infections should be given the possible benefit of an autogenous or stock vaccine.

If the patient has an allergy that has not been investigated or treated, that should be the first step. Although I frequently prescribe anti-histamines, I have not been impressed with their effectiveness in secretory otitis media. Theobald¹⁷ has reported a similar experience in this regard. Food allergy is a common primary or contributing factor in infants and young children. At times a change in the formula is all that is necessary in infants, but more often a complete allergic investigation is indicated in older children. If the allergic child has hypertrophied adenoids and the ears do not respond to allergic treatment, the adenoids should be removed surgically.

II. Remove fluid and clotted secretion from tympanum—

The mechanics involved in evacuating the fluid from the middle ear are not difficult, but the procedure can be facilitated by following certain principles.

1. Explain to the patient at the first visit that he may have a recurrence of symptoms soon after the drum has healed, and that a prolonged course of treatment may be necessary.

2. Preliminary Politzerization or inflation. Preliminary inflation temporarily neutralizes the negative pressure in the tympanum and displaces the drum laterally and away from the promontory. I prefer

to use Politzerization because it is easier, both ears can be inflated at the same time, it is less painful to the patient, and it eliminates the risk of traumatizing the Eustachian orifice with the hard beak of the catheter. There are times when a tube cannot be inflated by Politzerization and a catheter must be used.

3. Myringotomy or needle aspiration—

Make the incision in the drum large enough, particularly if the fluid is thick and mucoid in type. If one avoids scratching the promontory with the point of the knife, the incision is almost painless even if no topical anesthetic is used. One does not need to be concerned about the incision not healing because it always heals too soon. A cruciate incision or a counter opening at a higher level in the drum is helpful in evacuating the thicker secretions.

4. Re-inflation-Politzerization—

A drop or two of fluid may drain out of the tympanum when the drum is opened as the result of the preliminary inflation, but the remaining fluid must be forced out by re-inflation. Remove as much fluid as possible by employing Politzerization with the head tilted forward and toward the involved side.

5. This is followed by spot suction, mass suction, and at times Politzerization and suction simultaneously. It may be necessary to place the suction tip through the incision to pull out a mucus clot.

6. Self-Politzerization—

Instruct the patient or parent to employ self-Politzerization at home four or five times daily using a two or three ounce rubber bulb fitted with a nasal tip as recommended by Rawlins.¹⁸ This procedure is very helpful in preventing the recurrence of fluid in chronic cases, apparently because it delays closure of the incision, keeps the middle ear aerated, and prevents or delays the formation of a vacuum.

7. Creation of semi-permanent perforation—

If fluid continues to recur in adults after several myringotomies, and one has exhausted all possible measures to correct underlying etiologic factors, then a semi-permanent perforation in the drum is justified and often rewarding. This can be done by using a corneal trephine as employed by Hotchkiss,¹⁹ by fulguration as suggested by Robison,⁵ or by using a small insert of polyethylene tubing (#444 TB-D) as recommended by Armstrong.²⁰ This latter method appeals to me as being the one of choice, and I am using it in an increasing number of chronic cases. The tubing is removed after two to five weeks and if, after closure of the drum, fluid again accumulates, the procedure can be repeated, leaving the tube in for a longer period.

III. In order to restore the patency of the Eustachian tube we should remove or correct any me-

chanical obstructions or structural deformities that may promote chronicity.

1. Correct malocclusion in adults—

Patients with obvious or suspected malocclusion should be referred to a competent orthodontist. Overclosure of the bite due to missing teeth is the most common form, and treatment is directed toward opening the bite and correcting the inter-maxillary distance.

2. Marked deviations of the nasal septum, hypertrophy of the posterior end of the lower turbinates, and polypi in the nose or posterior choanae are predisposing factors and should be corrected.

3. Carcinoma of the nasopharynx must be kept in mind in adults with serous otitis media and repeated biopsies taken in suspected cases.

4. Removal of hypertrophied adenoids and lateral pharyngeal bands—In my opinion, serous otitis media, recurrent or chronic, in children with enlarged adenoids or recurrent adenoiditis and tonsillitis is a definite indication for adenoidectomy and often tonsillectomy as well. The adenoid tissue should be removed thoroughly, preferably under direct vision as advocated by Meltzer.²¹ If the lateral pharyngeal folds are hypertrophied, they can be removed with punch forceps. Reeves and Brill²² advise removal of these folds if they are wider than five mm. If there is fluid in the middle ear at the time of operation, a myringotomy should be done at the same time and the fluid aspirated by spot suction. (The decision to open the drum should be made before the child is on the table because in the recumbent position with the head turned toward the opposite side, the fluid will drain back into the mastoid cells and away from the drum, leaving the false impression that no fluid is present, unless the middle ear is entirely full.)

Instead of a knife, I use a short bevelled 18-gauge spinal needle attached to a glass adapter and to the suction tubing. This enables one to make the opening in the drum and aspirate the fluid at the same time. The fluid can be collected in the glass adapter for cytologic study if desired.

5. Post-operative external irradiation—

In my experience, irradiation has not been a satisfactory substitute for surgical removal of the adenoids. If the secretory otitis media recurs after adenoidectomy and the nasopharynx is relatively free of lymphoid masses, I advise external irradiation aimed at the retropharyngeal lymph nodes. Also if a child has required a second adenoidectomy, I feel that irradiation to the nasopharynx should be given post-operatively to discourage the proliferative activity of the secondary lymphoid nodules.

Results of Treatment in Children With Chronic Secretory Otitis Media

I have recently reviewed and analyzed my results

in children with recurrent and chronic secretory otitis media who were treated for hypertrophied adenoids or diseased adenoids and tonsils.

One group of 21 children was treated with external irradiation to the nasopharynx by a competent radiologist. Seventeen of these children were observed for periods of not less than one year after irradiation. They received from 800-1600 r. (air dose) to each side, the majority receiving 900-1200 r. Although this series of 21 cases is too small to draw any definite conclusions, there seem to be some trends discernible. The results are shown in Table I.

Approximately 58 per cent of the children treated were cured or definitely improved. (Ten of 17 cleared, including six who had one or two recurrences.) However, 80 per cent of those cured or improved by irradiation had had previous adenotonsillectomy. All of the six not improved by irradiation had nasal allergy, but so did six of the 10 who were improved.

Another group of 54 children was treated with adenoidectomy or adenotonsillectomy. This series represents only children with recurrent or chronic secretory otitis media who were followed for a period of not less than one year after surgery. Most were followed for one to four years. Myringotomy was performed on approximately half of these children at the time of operation. The results are shown in Table 2.

A total of 49 of the 54 were eventually cured (90 per cent). Four of these required a secondary adenoidectomy. At least nine of those cured had nasal allergy.

These results are quite similar to those I reported

	Total	Previous T. & A. Or Adenoidectomy	Evidence of Nasal Allergy	T. & A. Or Adenoidectomy Done Later
Ears Cleared /c No Other Trt. or Recurrences	4	3	2	0
One Recurrence— Then Cleared	4	3	2	0
Two Recurrences— Then Cleared	2	2	2	0
One Ear Cleared. No Im- provement in Other Ear	1	1	0	0
No Improvement	6	3	6	3
Insufficient Follow-up (Either not seen or had not cleared when seen one month later.)	4	4	2	0
TOTALS	21	16	14	3

TABLE 1
RESULTS OF EXTERNAL IRRADIATION IN CHRONIC SECRETORY
OTITIS IN 21 CHILDREN

in a previous series ² in which 13 of 24 children were cured by external irradiation or radium applicator, and 19 of 22 children were cured by adenotonsillec-
tomy.

IV. Mastoidectomy—

I previously felt that mastoidectomy might be justified in certain chronic cases, but at present it is my opinion that mastoidectomy is rarely, if ever, indicated in secretory otitis media, because it does not correct the pathology in or around the Eustachian tube. I have seen simple mastoidectomy fail to cure two cases of chronic serous otitis media, and I have observed fluid in an adult fenestrated ear on two occasions.

Conclusions

1. Secretory otitis media is the most common cause of hearing impairment in children and is increasing in frequency.
2. The increase in the number of chronic cases is due in part to hypovirulent infections and the unjustified confidence in antibiotics, which mask symptoms and often fail to relieve the Eustachian tube obstruction.
3. A plea is made for careful follow-up observation when antibiotics are used in the acute inflammatory otitis medias and for the more frequent use of myringotomy for drainage when indicated.
4. The diagnosis of secretory otitis media is not difficult but is still being missed by those not familiar with this disease. The diagnosis is made by the history, the characteristic appearance of the drum, and in doubtful cases by a diagnostic paracentesis.
5. The objectives in the treatment are to rid the middle ear of fluid, prevent its recurrence by correcting the underlying cause and restoring the func-

	Total Patients	T. & A.	T. & A. and 2nd Adenoidectomy	Adenoid. Only	Evidence of Nasal Allergy
Cured (No Recurrences)	39	33	4	2	9
One Recurrence Then Cleared	7	7			0
Two Recurrences Then Cleared	3	3			0
One Ear Cleared No Improvement In Other Ear	1	1			0
No Improvement (More Than Two Recurrences)	4	2		2	2
TOTALS	54	46	4	4	11

TABLE 2
RESULTS OF TREATMENT OF CHRONIC SECRETORY OTITIS MEDIA
BY ADENO-TONSILLECTOMY OR ADENOIDECTOMY

tion of the Eustachian tube, and thereby restore and preserve good hearing.

6. The prognosis is good in the majority of cases, and hearing returns to normal when the fluid is evacuated unless there are adhesive processes or pre-existing nerve deafness.

7. Treatment in chronic cases will be successful only if the underlying cause is corrected. In adults this is most often a sinus infection and less commonly allergy, malocclusion, and malignancy of the nasopharynx. In children, hypertrophied or diseased adenoids are the chief causes, followed in importance by ethmoiditis and allergy.

8. Chronic secretory otitis media in a child with hypertrophied adenoids is usually an indication for adenoidectomy. If there is a history of recurrent tonsillitis, the tonsils should be removed at the same time.

9. Irradiation is not a satisfactory substitute for surgical removal of the adenoids, but is used in selected cases post-operatively to discourage secondary proliferation of lymphoid tissue, and to shrink the lateral retropharyngeal lymph nodes.

14 Medical Arts Square

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Special Notice

AT THE 1956 SESSION of the General Assembly of Georgia the Medical Practice Act was amended to require all men and women licensed to practice medicine in Georgia to pay an annual registration fee of \$3.00 in December of each year. If the fee is not paid before January 1st the fee will be \$10.00.

We are quoting Section 84-913, paragraph 2, of the law:

"All licenses to practice medicine shall expire on December 31 of each year and shall become invalid on that date unless renewed. The fee for renewal shall be \$3.00. On December 1, the Joint Secretary, State Examining Boards, shall mail to each person holding a license to practice medicine a blank to be used in apply-

ing for renewal of his license and a statement of the fee.

"Upon receipt of the application and renewal fee, the Joint Secretary, acting under the direction of the State Board of Medical Examiners, shall be authorized to renew a license. Failure to apply for renewal of a license and to remit the renewal fee during the month of December shall not withdraw the right of renewal, but the renewal fee if submitted after December 31 shall be \$10."

If you did not receive a notice on or before December 1, 1956, please contact the office of C. L. Clifton, Joint Secretary, State Examining Boards, 224 State Capitol, Atlanta, Georgia.

Diagnosis of Myoglobinuria with Special Reference to the Primary Type in Man

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MYOGLOBIN IS AN IRON-CONTAINING respiratory pigment of muscle and is found in greatest quantity in the red-muscle groups of man and other animals. In general, myoglobin is present in the highest concentration in those muscles whose function requires relatively slow repetitive, vigorous activity with contractions of the order of 1 X/sec., which must be maintained (for example, hearts of mammals, breasts of large birds, legs of running animals). Unlike hemoglobin, myoglobin is not free to circulate and is not found in the plasma or urine under normal conditions. Myoglobin has been called "muscle hemoglobin," and indeed it belongs to the group of hemoproteins comprising an iron-containing prosthetic group, protophorphyrin, together with a protein component, globin. It appears to function as an oxygen reservoir for use in the recovery or regenerative phase of muscular contractions. It is by no means the only iron-containing component of muscle, others being cytochrome, cytochrome oxidase, peroxidase, and catalase. Although it is similar to hemoglobin in some aspects, myoglobin has distinct physical and chemical properties which distinguish it from the other iron-containing respiratory pigments of the body. One physical property of myoglobin which is of great help in the differentiation from the pigment hemoglobin is its relatively low molecular weight, being of the order of about one-fourth that of hemoglobin, 17,500/68,000. Because of the relatively small molecular weight, myoglobin is readily filterable at the glomerulus and is thus rapidly cleared from the plasma so that the plasma concentration never rises sufficiently to give a red color to the plasma. In disease states, the concentration of myoglobin found in muscle tissue is not directly correlated with the amount or the state of hemoglobin in the body. Thus the myoglobin content of the body is not necessarily reduced in anemia, nor is myoglobin found in the plasma or urine in hemolytic states.

Since myoglobin is so rapidly excreted in the urine, the first evidence of the existence of a pathological state is frequently a dark red-brown urine, and hence the disease has been termed Myoglobinuria.

Classification

PRIMARY MYOGLOBINURIA (Similar to equine paroxysmal paralytic myoglobinuria)

SECONDARY MYOGLOBINURIA

crush syndrome

high voltage accident

arterial occlusion with ischemia

Haff disease

progressive muscular dystrophy (?)

myositis (?)

Myoglobinuria may be classified into primary and secondary types. The secondary type is of definite etiology and follows known trauma, either mechanical, chemical, or physiological, to large areas of muscle tissue. The primary or idiopathic type is of unknown etiology and may be paroxysmal. Possibly because of its rareness, it has been intriguing to investigators and has stimulated research on the nature, function, and properties of myoglobin in general. As the secondary type of myoglobinuria is much more familiar and is usually much less of a diagnostic problem, only the primary type will be discussed in detail.

Briefly stated, the clinical picture of primary myoglobinuria is an acute onset of fever, chills, and weakness. The urine is noted early to be colored a dark red to brown. There may be muscle pain, loss of strength, and in some cases paralysis—with the legs being the earliest and most prominently involved. The upper extremities as well as the tongue, jaws, and intercostal muscles, may be involved. The absence of anemia, hemolysis, and evidence of red cell destruction, associated with a red pigment in the urine which gives a positive benzidine test, is strongly suggestive of myoglobinuria. If added to these findings there is evidence of acute renal insufficiency without any precipitating cause, one is almost certain to be dealing with Primary Myoglobinuria. It is

Presented at the 106th Annual Session of the Medical Association of Georgia, Atlanta, May 13-16, 1956.

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believed by some that there is a predisposing familial or heredity factor necessary and that in these susceptible persons some trigger mechanism precipitates the symptoms of myoglobinuria. This mechanism has been most frequently reported as strenuous exercise. Some have claimed that a relationship exists between progressive muscular dystrophy and primary myoglobinuria, considering both diseases to be different phases of the same illness. An abnormal glucose tolerance curve as well as creatinuria have been noted in some, but by no means all, of the reported cases. At the present time, however, it must be said that the problem of the etiology of primary myoglobinuria remains unsolved.

The renal lesion is acute tubular necrosis (lower nephron nephrosis). This disease may be paroxysmal and occur at any age, and, although every episode may not be accompanied by acute uremia, evidence of renal damage to some degree will be found if sought for. As the kidney lesion, whatever the extent, is apparently essentially one of tubular necrosis, there may be so-called complete recovery following the attack. We further suggest, however, that although varying degrees of tubular damage may occur with different paroxysms, the chance of a patient's being predisposed to chronic renal insufficiency following repeated attacks is excellent. Also the possibility of the patient's developing acute renal insufficiency following any given paroxysm is very likely. The patients who succumb to this disease have died in acute uremia. The explanation for the occurrence of renal damage with the excretion of myoglobin, hemoglobin or any other type pigment, is not readily available. Experimental work along this line has been confusing to say the least. Briefly stated, we feel that the cause of the renal lesion is some degree of renal ischemia resulting in a reduction in the glomerular filtration and/or renal blood flow and not of necessity associated with peripheral circulatory collapse.

The acute clinical symptoms of fever, myalgia, weakness, and the passage of a dark urine should alert one to the possibility of the presence of myoglobinuria. The laboratory findings of no anemia and no evidence of hemolysis in the serum and a dark urine without red blood cells but a strongly positive benzidine test should make one more suspicious. The final and certain diagnosis, however, is made by the identification of the pigment in the urine. Most investigators have relied on the spectrophotometer and the ultracentrifuge. We have devised a third method using paper electrophoresis which we feel is not only simple and more rapid, but also offers an accurate identification of the pigment as well as a definite differentiation from hemoglobin. These three methods can be demonstrated by the

findings in a case of primary myoglobinuria recently seen by us.

Ultracentrifugal analysis was carried out using the Spinco Model E, analytical ultracentrifuge. Our values for the sedimentation constants agreed quite well with the values for myoglobin reported by other investigators. These results furnished substantiating evidence; however, the procedure is long, requires expensive equipment, and is not readily adaptable to the routine laboratory.

There are certain well-known difficulties in the spectroscopic differentiation of myoglobin and hemoglobin. Both substances may exist in the oxygenated and the oxidized or met state. Since myoglobin is very readily oxidized on exposure to air, mixtures of both oxymyoglobin and metmyoglobin are usually present in the specimen to be analyzed. This fact causes variations in the curves which are often difficult to interpret. These difficulties can be overcome somewhat by specific conversion of the myoglobin to oxymyoglobin, metmyoglobin, or to

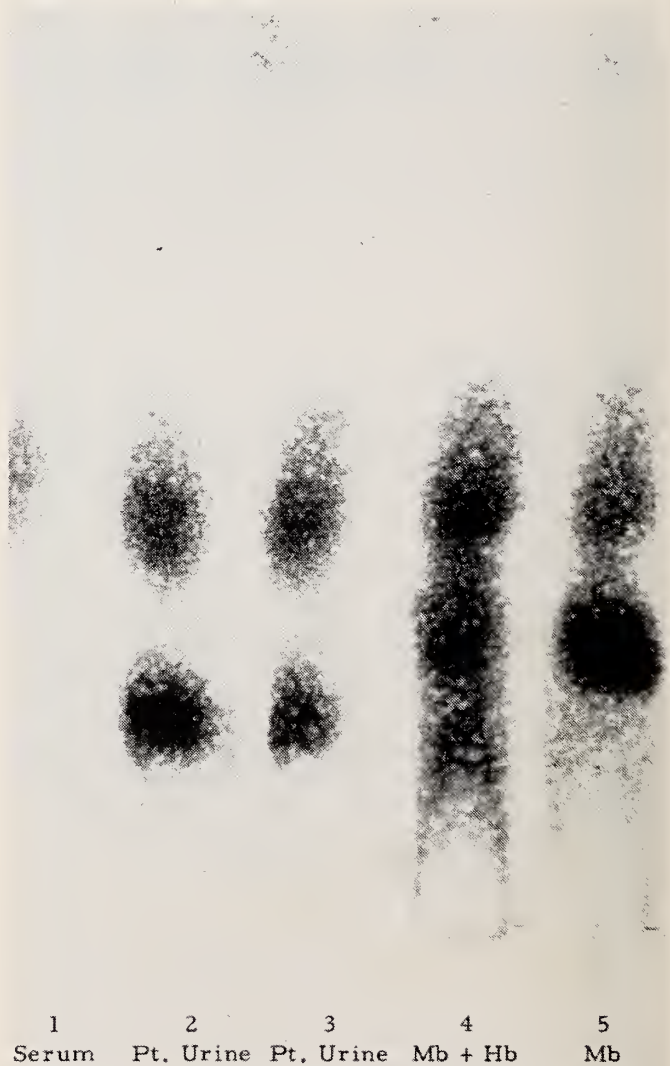


Figure 1
Note that myoglobin migrates only half the distance of hemoglobin.

Georgia Heart Disease Control

SOME CHANGES IN THE HEART disease control program of the Georgia Department of Public Health have been made. J. Gordon Barrow assumed its direction in June, under the supervision of L. M. Petrie, Director of the Division of Chronic Diseases.

There are now 14 heart clinics in operation in the State. The clinic at the Wayne County Health Department, in Jesup, has been reactivated under new direction. In addition, a clinic at Gainesville, in Hall County, will be ready as soon as the new health center is completed.

A new and enlarged prophylaxis program against rheumatic fever was launched July 1. Sulfadiazine is the basic drug being used for everyday prophylaxis. This drug is furnished to the clinics in bottles of a month's supply of the medication with the recommended dosage. Special labels have been printed for

this purpose, explaining the use of the drug as prophylaxis against rheumatic fever.

A supply of injectable all-purpose bicillin is being furnished to the clinics for use in cases of sore throats or other respiratory infections which might be streptococcal and which occur despite the daily prophylaxis. The oral bicillin which has previously been purchased will be saved for the use of those sensitive to sulfadiazine.

A monthly report on the use of these drugs and the results obtained is required. From this report, it is expected some valuable information on incidence of rheumatic fever will be obtained, as well as results of the prophylaxis program.

The entire prophylaxis program has been approved by the Rheumatic Fever Committee and the Board of Directors of the Georgia Heart Association.

Diagnosis of Myoglobinuria . . . (cont'd)

the carboxy compound by treating with carbon monoxide. Even if present in a single pure form, the differentiation between oxymyoglobin and oxyhemoglobin is difficult as the alpha-band maxima are only three to four μ apart, and curves for the met compounds are almost identical. For these reasons the compounds are usually converted to the carboxy form, but the position of the alpha-band maximum here is only about 10 μ apart. The spectrophotometric curves obtained by us were satisfactory, but we did not feel that we had sufficient evidence for identification of the pigment.

Since the evidence obtained from the spectrophotometer and the ultracentrifuge was more compatible with, rather than diagnostic of, myoglobinuria, we were led to seek other means of identification. A specific analytical procedure using paper electrophoresis was devised and confirmed the presence of myoglobin in the patient's urine. One part of a benzidine-positive urine is added to two parts of human serum. The mixture is separated by paper electrophoresis and stained with a hydrogen peroxide-benzidine spray. The serum proteins prevent adsorption of myoglobin or hemoglobin, but do not stain. Human myoglobin migrates only half the distance of hemoglobin, thus easy differentiation is possible. See Figure 1.

Summary

A classification of myoglobinuria has been presented. The primary or idiopathic type has been discussed. The clinical picture has been given and the laboratory methods for identification of myoglobin in the urine have been shown. A new method

devised by us using paper electrophoresis has been demonstrated.

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Cancer of the Breast—As Found

C. H. RICHARDSON, JR., M.D., and

THIS IS A GENERAL SURVEY of all breast cancer seen in the Macon Tumor Clinic from its founding, in 1937, through 1955. The clinic treats indigent persons from 20 surrounding counties and is associated with the Macon Hospital. Patients coming to the clinic are first examined by one of the attending surgeons who then supervises the hospital treatment performed by the resident staff. Cases treated through 1942 have been previously reported by Harrold and Etheridge¹ and are included here. They concluded from their study, which was based on private and clinic patients, that patients with breast cancer were coming for treatment sooner and in a more favorable stage for curative therapy than previously.

Our purpose in making this survey is to describe the total number of clinic breast cancer cases in terms of stages of the disease seen, management of treatment, and the results of treatment.

Material

During this 18-year period, over 8,000 new patients have been seen. From these records we found that there were 407 malignant breast tumors, or approximately 25 new cases each year. Of these, 402 were female and five male, 242 colored and 164 white. The age distribution by decades showed the highest incidence between 50 and 60 years of age with average age at 54 years. Our age incidence appears higher than most reported series which show a peak incidence in the fifth decade.^{2 3 4} (Table 1).

Age	Number of Cases	Percentage
Under 30	10	2.5%
30-39	48	11.9%
40-49	88	21.7%
50-59	105	25.9%
60-69	83	20.5%
70 & over	71	17.5%
Total	405	100.0%

TABLE 1
Age Incidence of Carcinoma of Breast

The duration of symptoms before the first clinic visit averaged 18 months. Only 43 per cent of our patients had a history of a mass in the breast for six months or less. This shows considerable delay in reaching definitive treatment when compared with other series such as Boyd⁵ who reported 50-55 per cent under six months and Zellinger,³ 70 per cent under six months. Comparing the figures for the first five years of the series (1938-1942) with the last (1951-1955), we found no change in spite of the

intensive efforts of the American Cancer Society and physicians in general in urging the public to seek medical advice early for breast lumps. (Table 2)

	Less than 6 mo. No. %	More than 6 mo. No. %
Entire series (1938-1955)	147 42%	201 58%
First 5 yrs. (1938-1942)	37 43%	51 57%
Last 5 yrs. (1951-1955)	43 43%	56 57%

TABLE 2
Duration of Symptoms

The size of the tumor gives another indication of advancement of the disease. In 355 cases in which the size was accurately stated in the records, 164 or 46 per cent were over five cm. in diameter when first seen. (Table 3)

	No.	%
Less than 2.5 cm.	60	16.9%
2.5-5 cm.	131	36.9%
More than 5 cm.	164	46.2%
Total	355	100.0%

TABLE 3
Size of Tumor

In attempting to evaluate further the extent of disease, a modification of the Portmann⁶ classification was used. Stage I includes cases with disease limited to breast; Stage II, disease involving the breast and axillary nodes; Stage III, disease far advanced locally and considered inoperable; and Stage IV, those having distant metastasis present. Judged in this way 21 per cent were in Stage I, 29 per cent in Stage II, and 50 per cent of the total of 407 cases were in Stage III and IV, 86 showing distant metastases on their initial visit. Again comparing the first and last five year periods we found no change. (Table 4)

	Entire Series (1938-1955)	First 5 yrs. (1938-1942)	Last 5 yrs. (1951-1955)
Stage I	88 21%	22 22%	25 21%
Stage II	118 29%	27 27%	33 28%
Stage III & IV	201 50%	51 51%	59 51%
Total	407 100%	100 100%	117 100%

TABLE 4
Clinical Classification
Comparison of Early and Recent Cases

Pathology

Histological diagnosis was recorded in 248 of the cases. During the early years, advanced cases were diagnosed on clinical grounds only, but in recent years needle biopsies have been made as often as possible. The various diagnoses made are listed in Table 5. An attempt to correlate these with five-year

Presented at the 106th Annual Session of the Medical Association of Georgia, Atlanta, May 13-16, 1956.

in a State Tumor Clinic

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results gave groups too small to be statistically significant. More meaningful was the extent of axillary node involvement. This showed that 86 of 179 had node involvement, an incidence of 49.6 per cent in the operated cases. It is considered likely that the actual incidence of positive nodes was considerably higher, as many of these examinations were made rapidly in the ordinary routine of a busy hospital without the personnel or time for prolonged search of all node tissue.

Adenocarcinoma (96.8%)		
Scirrhus	84	33.9%
Unclassified	65	26.2%
Medullary	32	12.9%
Carcinoma Simplex	25	10.1%
Duct Carcinoma	13	5.3%
Comedocarcinoma	10	4.0%
Papillary Carcinoma	6	2.4%
Colloid Carcinoma	5	2.0%
Paget's Disease	2	0.8%
Squamous Cell Carcinoma	1	0.4%
Teratoma	1	0.4%
Sarcoma	4	1.6%
Total	248	100.0%

TABLE 5
Pathology

Treatment
Of the 407 cases, 362 were primary and 45 had received some treatment elsewhere. Previous biopsy reports were obtained and further treatment given the secondary group. These have been included wherever they could be classified in estimating the final results.

In determining operability the surgeons of the Macon Tumor Clinic have in general followed the criteria of Haagensen and Stout.⁶ Cases without distant metastases have received radical mastectomy whenever it was felt there was any hope of surgical eradication of the disease.

Seven of our cases, through 1950, showed carcinoma occurring during pregnancy or lactation. One of these who received radical mastectomy, x-ray, interruption of pregnancy, and oophorectomy has survived seven years in spite of node involvement at operation. Nine cases were recorded as inflammatory carcinoma, and none survived five years regardless of treatment. In recording operability we have taken the judgment of the surgeon handling the case even though in retrospect some were probably inoperable, by present standards, at the time of the first visit. The overall operability rate was 195 out of 407 or 45.4 per cent. This figure is far

below the operability rate of 80.3 per cent reported by Adair⁶ and 74.1 per cent reported by Haagensen and Stout.⁷

Surgical Treatment

In the early years, simple mastectomy was often done first and the breast examined. If malignancy were found, the pectoral muscles and axillary contents were then removed. Now, all operable cases have either excisional or incisional biopsy and frozen section with a wide radical dissection and skin graft. We believe this technique leads to fewer local recurrences and quicker healing. Constitutional factors led to the use of simple mastectomy more frequently in the earlier years before the advent of the blood bank, modern anesthesia, and improved medical preparation. It is still performed in the very aged or poor risk patients, coupled with x-ray therapy. Occasionally this procedure is used to remove a foul ulcerating lesion in an otherwise inoperable case.

Extension of radical mastectomy to include the internal mammary nodes as described by Urban⁹ has been performed in only one instance. It is our present feeling that this procedure should be reserved for an occasional selected case.

Pre-Operative and Post-Operative X-Ray

During the years 1937-1945 surgery was usually preceded by a full x-ray cycle. This was given using four ports, and an attempt was made to deliver up to 2400 R. in air to each. The 200-250 KV machine at 50 cm. with 1/2 mm. copper and 1 mm. aluminum filters was employed. This often brought about a remarkable regression of the tumor, but surgery was delayed six to eight weeks, and fairly often the patient refused further treatment. For these reasons, pre-operative x-ray was discontinued as routine in 1946, and post-operative x-ray was given if the axillary nodes were found to be involved. This amounted to total dosage of from 4000 to 6000 R. in air using three ports. This continues to be our routine, and as seen in Table 6 the end results with both methods are very similar.

	Number of Cases	5 yr. Survivals	
			%
Pre-op x-ray therapy and Radical Mastectomy (1938-1945)	64	25	39.0%
Radical Mastectomy and Post-op x-ray therapy (1946-1950)	65	25	38.7%

TABLE 6
Comparison of Results with Pre-operative and Post-operative x-ray therapy

Palliative Therapy

Since half of the cases were far advanced when first seen, palliative therapy has played a very important part in the clinic's work. The philosophy has been to employ radical mastectomy in all operable cases except when simple mastectomy, followed by x-ray therapy, was performed in operable cases who could not tolerate radical surgery. However, if a case were clearly inoperable, the greatest palliation was usually effected by giving x-ray therapy alone. This was given up to skin tolerance limits, and repeat series were given as often as needed and tolerated.

Hormones, especially testosterone in its long acting form, have been used freely along with x-ray with very good effect. In older women five years or more past menopause, Stilbesterol has occasionally brought a gratifying regression of soft tumor masses.

Oophorectomy was employed in younger women with recurrences and sometimes produced good palliation. Total adrenalectomy as described by Huggins¹⁰ was done in two cases with relief of pain for a few months, but the exacting care required afterward in the face of advancing disease did not make this a very encouraging procedure for our clinic patients.

Results of Treatment

In judging results, only cases seen from 1937 to 1950, a total of 290, who were followed five or more years have been analyzed. Of these, radical mastectomy was done in 129 with 50 known five-year survivals, a rate of 39 per cent. Simple mastectomy and x-ray therapy were done in 25 cases with eight five-year survivals, or 32 per cent. X-ray palliation alone was given to 83 with seven five-year survivals, or 8.4 per cent. In addition, 14 cases refused all treatment, and 35 were hopeless when first seen and not suitable for anything but terminal care. It was also noted that of the total number of 142 operable cases, nine refused surgery and four others failed to complete treatment. (Table 7).

	Number of Cases	Known 5-year Survivals No.	%
Radical Mastectomy	129	50	39%
Simple Mastectomy	25	8	32%
Palliative x-ray	83	7	8%
Refused Treatment	14	0	0
Terminal Care Only	35	0	0

TABLE 7
Disposition and Survival of all Cases

In order to find the five-year survival in the operable group as well as the five-year "clinical cure" rate, attempt was made to follow the 129 radical mastectomies more carefully. Letters were written and attempts made to contact the referring physicians and welfare offices in the counties from which the cases came. Unfortunately these efforts were not always successful, and this is a real weakness of a clinic that must depend mainly on complete coop-

eration of the aged, infirm, and indigent patients who come 25 to 100 miles for their visits.

Of the 129 radical mastectomies, 27 were lost to followup before five years while still free of disease. These have been eliminated from the total number in calculating results. All patients who were lost with recurrent disease were considered dead of disease. When the 102 cases so operated and followed were analyzed, it was seen that 50 survived five years; 41 of these were free from disease. Of those with axillary metastases, 30.6 per cent survived five years, but only 18.4 per cent were living five years free of disease. Those who had no axillary metastases showed a 66.6 per cent five year survival and a 60.4 per cent "five-year cure rate." (Figure 8) These figures are compared with survival rates reported from other clinics in Table 9.

	All Cases Number	Without Axillary Metastases 66	With Axillary Metastases 63
Lost without evidence of disease	27	12	15
Number fol- lowed 5 yrs. 102		54	48
Dead of disease	52	19	33
5 yr. survival	50 49.0%	35 66.6%	15 30.6%
5 yrs. free of disease ...	41 40.2%	32 60.4%	9 18.4%

TABLE 8
Results of Radical Mastectomy

	Overall Survival Percentage	Survival with Axillary Metas. Percentage	Survival without Metas. Percentage
Adair, Memorial Hospital, New York City	54.4	39.4	77.5
Harrington, Mayo Clinic	51.2	32.5	78.3
Marshall, Lahey Clinic	52.	37.0	75.0
Guthrie, Guthrie Clinic	52.	46.0	76.0
Zellenger, New Rochell Hosp., San Francisco	44.9	37.0	75.0
Garland, St. Josephs Hosp., San Francisco	53.0	40.0	65.0
Macon Tumor Clinic, Macon, Ga.	49.0	30.6	66.6

TABLE 9
Five-Year Survival after Radical Mastectomy

Complications

The operative mortality was five deaths out of 179 radical mastectomies done 1938-1955, a rate of 2.8 per cent. However, in the last 103 cases done since 1946 there has been no surgical mortality. This is in spite of the fact that resident surgeons perform most of the operations, and few patients are turned down for constitutional reasons.

It was our impression that post-operative edema was due most often to infection and was not particularly severe.

Local recurrence occurred after both simple and radical mastectomy. In the latter, in cases followed five years, it was recorded only in 14 cases out of 102 or 13.7 per cent.

The Christmas Season

This is the season for reaffirmation of faith—faith in God and humanity, and for reaffirmation of our belief in the basic principles of the practice of medicine. Let us, this Christmas, restate these principles of our profession:

“With every fiber of my being, I believe that the unlimited choice of physician, the free selection of patient, the unqualified responsibility of physician to patient, the unhampered exercise of professional judgement, and the direct reward for individual initiative form the only possible basis for the acceptable medical care of free man.”¹

“One who furnishes professional services can have no limit put on his financial liability or on his professional honor. The professional man does

not advertise; he may not hide behind the anonymity of the corporate fiction; he must risk his professional reputation on every decision he makes.”²

Such statements as these help to remind us of the fundamental nature of our practice which is often overlooked in the rush of daily work.

Take a few minutes this month and reread the Oath of Hippocrates. Read from the writings of Sir William Osler, who reminds us that medicine should never be a business; it should be a calling much like the ministry.

1. “A Small Leak Will Sink A Great Ship”, G. Westbrook Murphy, M.D., Asheville, N. C., *J. So. Car. Med. Assn.*, October, 1956.
2. From letter to Richmond County Medical Society from the Council of the Medical Association of Georgia.

Cancer of the Breast . . . (cont'd)

Summary

Four hundred seven cases of breast cancer were seen in the Macon Tumor Clinic from 1937-1955 inclusive. As a group these cases showed an advanced stage of the disease with an average duration of symptoms of 18 months, tumor over five cm. in diameter in 46 per cent, and tumor operable in only 45.4 per cent of the cases.

Comparisons of the first five years, 1938-1942, and the last five years, 1951-1955, as to duration and stage of disease show no change that would indicate any improvement in reaching definitive treatment earlier.

Treatment consisted of radical mastectomy for operable cases, with simple mastectomy plus x-ray therapy for poor risk patients. Occasionally simple mastectomy has been done to remove an ulcerating lesion for palliation. In most Stage III and Stage IV cases and for recurrences, x-ray therapy was used for palliation, with hormones, oophorectomy, and in two instances adrenalectomy as adjuncts.

Results in 290 cases through 1950 show known five-year survivals for 127 radical mastectomies of 50, or 39 per cent. In 25 simple mastectomies with x-ray, eight or 32 per cent, are known to have survived five years. Palliation with x-ray therapy was used in 83 cases with seven survivals, or 8.4 per cent.

Of 102 radical mastectomies followed for five years, those without node involvement showed 66.6 per cent five-year survival and 60.4 per cent “clinical cure” rate. Those with node involvement showed a 30.6 per cent survival and 18.4 per cent “clinical cure.”

The operative mortality for radical mastectomy during the entire period was 2.8 per cent with no

death in the last 103 cases. The local recurrence rate was 13.7 per cent. A disappointing number of cases were lost to follow-up, and seven per cent refused surgery.

Conclusions

1. Breast cancer cases are reaching the Macon Tumor Clinic in a late stage of the disease. This is not improving at the present time.

2. The follow-up on these cases leaves much to be desired.

3. In favorable Stages I and II, the standard treatment by radical mastectomy is producing results comparable, or slightly lower than, those reported by larger clinics.

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Gastrointestinal Allergy in Infancy and Childhood

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BY GASTROINTESTINAL ALLERGY is meant an allergic reaction in an organ of the gastrointestinal tract. While such reactions most commonly occur from food, they may rarely be produced by allergens of other origin, as for example, ulcerative colitis, due to inhaled pollen as described by Rowe and associates.²⁹ By food allergy is meant an allergic reaction caused by food, regardless of the tissue in which it occurs, as atopic dermatitis in infancy due to the ingestion of milk or egg.¹³

In this short space, it is impossible to deal thoroughly with all the various allergic manifestations which the gastrointestinal tract may present. I shall, therefore, limit my discussion to those which I consider of the greatest importance, and the first of these is the "ordinary" infantile colic.

"Ordinary" Infantile Colic

Our fundamental knowledge of what is termed "colic" is so uncertain that it is appropriate in discussing this subject to quote a remark by Tenney,³⁴ "And so it is with colic; maybe there is no such thing but there is certainly something that makes some perfectly healthy babies cry almost unbelievably loud and long without interfering with their perfect health."

Due to the fact that little attention is paid to colic in medical schools, this disorder has rarely received the attention of the full time academic pediatrician (unless he has experienced it in his own family) and, for that reason, medical students and house officers all too commonly encounter this frustrating problem only on starting private practice, when it becomes a matter of great importance and concern. As pointed out by Levin²¹ colic does occur in institutions but is commonly overlooked because of the failure of the nurse to call the attention of the attending physician to the crying babies, failure of the physician to diagnose the condition correctly, and probably other factors, the chief of which is, in my opinion, that there is no parent constantly with the child to worry about it and keep bringing the crying

to the attention of the doctor. Colic, in varying degrees of severity, occurs so commonly that it may be considered in most instances a physiological phenomenon. It usually starts during the second or third week of life and terminates, regardless of therapy, by the time the infant is three months of age, hence, the not too inaccurate lay term, "three-month's colic."

In the words of Brennemann:⁷

"Colic is merely a symptom (but there is want of agreement as of what it is a symptom). It is of such frequent occurrence and is so distinctive in its manifestations that it has come to be looked upon as a sort of clinical entity in itself. It is an almost infallible occurrence sometime in early infancy. Few infants escape it. A phenomenon so frequent at least borders on the normal."

Brennemann has also given a very vivid description of colic as follows:

"Colic manifests itself in intermittent, paroxysmal attacks of sharp, intense pain clearly referable to the intestinal tract. The pain of colic is agonizing, it is not a mere discomfort. The baby screams with recurrent pain as he does with nothing else in all infancy. He draws up his legs as if to make pressure on his abdomen, his whole body becomes suffused and red, and he often sobs for a long time after the pain is relieved. It usually begins suddenly, often ends equally suddenly, sometimes only to begin again. It has a striking periodicity. This varies with individual babies but has a marked tendency to recur daily in the late afternoon, or early evening at about the same hour and to last for about the same length of time for each baby . . . The striking similarity of this type of colic to other acute types of colic is evident, such as gas pains after abdominal operations and in peritonitis, the sharp intermittent pains of intestinal obstruction and of labor, and the excruciating pains of gallstone and renal colic."

Colic may be defined simply as a symptom complex of early infancy, characterized by evidence of intermittent abdominal pain of varying degrees of severity for which there is no evident organic or

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Presented at the 106th Annual Session of the Medical Association of Georgia in Atlanta at the General Session (G. P. Day), May 14, 1956.

physiological cause.¹⁴ The chief symptom, as above mentioned, is crying, and this may be almost a constant feature, so that the family life is disrupted, the parents and doctor are driven to distraction, and what should be a very happy experience may be transformed into a disagreeable nightmare. Some allergic colic may be accompanied by melena,³⁰ but fortunately these cases are not common. There are many causes of crying in infants besides colic, a discussion of which is beyond the scope of this communication. This has been fully considered by Illingworth.¹⁸

It is necessary to make a differential diagnosis of colic from distress caused by improper feeding, or pain caused by otitis media, or pyelitis, or surgical conditions such as appendicitis, Meckel's diverticulitis, intussusception, inguinal hernia; certain neurological disorders, as hypsarrhythmia,⁹ and many other conditions of varied origin.

It is an interesting fact that the major manifestations of allergic disease occur in three principal groups of tissues: the gastrointestinal tract, the skin, and the lungs.¹⁵ These tissues have one feature in common, and that is that they are all covered by epithelial layers. It is pointed out to every first-year medical student, for example, that the deepest niche of the gastrointestinal tract and the deepest alveolus of the lung is a direct continuation of the external body surface and is, therefore, in fact, a body surface. This fact, which is pointed out to the student as a curious anatomic situation, may perhaps have a deeper meaning. These tissues are the buffer tissues between ourselves and our environment. They are, therefore, the tissues most subjected to stress when the individual passes from the intrauterine environment to the outer world. Colic is the first clinical manifestation of allergy in the human being which rises to a clinical level, i.e., the first allergic disease of which the parents may complain. It seems reasonable to suppose that the first manifestation of allergic disease in the human being occurs in the intestinal tract which, because of the complexity of its structure and function, is subject to the greatest stress of any of these three groups of tissues following birth.

Brennemann⁷ has expressed almost the same thought in slightly different words:

"It would seem to me that the more *rational explanation of colic* is found in the fact that the baby comes into the world more underdone than the young of other mammals; that its intestinal tract is not yet equal in the earliest months to an unusual or even normal demand, either in the matter of digestion or of propulsion of its gaseous contents."

Colic probably is, as the above observations sug-

gest, related in some way to the normal development process in the gastrointestinal tract, the nature of which is not clearly understood. The best evidence to this effect is the work of Pierce.²⁴ He observed that the onset of colic, which in the full-term infant usually starts at the age of two or three weeks, in premature infants starts at an age commensurate with the degree of prematurity. That is to say, an infant born one month prematurely will not develop colic at the chronological age of two or three weeks, but rather at the age of two or three weeks plus one month.

Etiology of Colic

The etiology of the ordinary type of infantile colic is not at all well understood. The fine study of Levin and Bell²⁰ indicates that, in many instances, the crying of infants may be due to an unsatisfied need for oral gratification, or from abdominal pain caused by spasm of intestinal muscles as a part of the picture of the general hypertonicity of the infant. They reported remarkable relief by the use of the pacifier, i.e. simply allowing the infant to suck on a rubber nipple.

Brackett⁶ has suggested that colic may be caused by excessive volume of contents in the terminal ileum due to hypertonicity of the ileocolic sphincter which in some cases may be of congenital origin and suggests treatment by reducing the volume of food. He draws an analogy between spasm of the ileocolic sphincter and pylorospasm.

Like so many diseases of obscure etiology, infantile colic has not escaped the attention of the psychosomaticist. The mother of the infant with colic has been described as tense, anxious and uncertain; one who is inconsistent in her handling of the baby and often rejects him. The psychiatrist's explanation of the reasons for this personality include early rejection of the baby, rivalry with infant or husband, conflicts about accepting the feminine or maternal role, and her dependency needs. The picture is complicated by the fact that colicky attacks commonly occur late in the afternoon, perhaps due to fatigue of the infant. As Ruth Bakwin³³ points out, this is the time when the father comes home from work, just when the infant's distress is greatest. At night he may get little sleep because of the crying. It is not difficult to believe that the mother of the colicky infant is tense, anxious, and exhausted. This is transmitted to the infant, who can feel the tenseness of the mother's muscles when she handles the child for feeding or changing clothes, diapers, etc.

Colic occurs at an age when the gastrointestinal tract is being introduced to foreign proteins, either cow's milk or a variety of others which reach the infant in the mother's breast milk. Therefore it seems probable, when one is cognizant of the permeability

of the intestinal tract at all ages to unaltered protein, that some colic might well be due to sensitization to certain foods. Without going into any great detail, it may be said that the evidence of the allergic origin of colic may be divided into two classes: (1) presumptive and (2) specific. The presumptive evidence is as follows:

(1) There is a definite incubation period of 10 days to three weeks after birth before colic develops. This is analogous to the interval which must elapse in experimental animals following the injection of a foreign protein before an anaphylactic reaction can be produced by the reinjection of the foreign protein.¹³

(2) During the first few weeks of life, positive reactions to cutaneous tests occur which disappear as the child becomes accustomed to the new foods.¹⁰

(3) Transient precipitins to these allergens also occur in the blood stream during the same period.³¹

(4) Transient blood eosinophilia appears as new foods are introduced and disappears as the child becomes accustomed to these foods.⁴

(5) Infants who have had colic develop eczema more frequently than infants who had not had colic.³⁷

(6) Eosinophils may sometimes be demonstrated in the mucous of the stools of infants with colic.²⁵ In my experience, this procedure has been only occasionally helpful as it has not been easy to obtain clear mucous in the stools of most infants. However, when an eosinophilia can be demonstrated in the mucous of the stools, its significance may be regarded as the same as that of eosinophilia in the nasal smear. The burden of proof is on whoever claims that the condition is not allergic in origin.

In contrast to the above mentioned presumptive evidence that colic is of allergic origin, it is generally accepted that if there is definite relief by specific modifications of or changes in the protein of the diet that the colic is of allergic origin. For example, the most severe colic will sometimes disappear if a whole cow's milk formula is replaced by evaporated milk, or, if the infant is on an evaporated milk formula, by the substitution of a formula other than that of cow's milk. Goat's milk is ordinarily not a satisfactory substitute unless the sensitivity is to the lactalbumin of the milk which is species specific. In such cases merely heating the milk destroys the allergenicity of the lactalbumin so that goat's milk is seldom more satisfactory than evaporated milk where the lactalbumin has been denatured by heat in the process of preparation. If the sensitivity is to the casein, as is most commonly the case, goat's milk does not help because the caseins for all mammalian milks are essentially the same. As a substitute protein for a milk base, the soy bean is most commonly employed and is highly satisfactory. In those infants who

do not respond to soy bean milk, an equally good substitute is an artificial milk whose protein base is homogenized meat.¹² These meats are now commercially available so that this formula, which was first devised by Rowe²⁸ may easily be put to practical use.

Breslow³³ in a project designed for the purpose of making an analytical investigation of the causes of colic, has made a detailed study of 90 infants who seem to fit the usual definition of infantile colic. He has tabulated the causes of colic as a result of his studies as follows:

- (1) Poor feeding technique—2%
- (2) Hunger—11%
- (3) Carbohydrate intolerance—31%
- (4) Butter fat intolerance—11%
- (5) Allergy (particularly due to milk)—10%
- (6) Miscellaneous—13%
- (7) Idiopathic or psychosomatic—22%

It seems evident from the foregoing, to quote Ratner,³³ that colic is a protean disease not often due to proteins.

The symptomatic treatment of colic is of great importance. Levine²² has found, as mentioned previously, that the pacifier is often of great help in satisfying the infant's need for sucking, and many instances of colic can be relieved by this method.

As regards the drug treatment of colic, atropin, the old time favorite, has not been found very helpful, and atropin intoxication has occasionally resulted from its use. Phenobarbital may occasionally help in doses of one-quarter to one-half grain (15-30 mg.) Elixir of Benadryl (one teaspoon contains 10 mg.) in doses of 12 minims per pound of body weight per 24 hours is sometimes of value. Dr. William L. Bradford* suggested the use of Progestin in infantile colic. He felt that this hormone, which has a sedative effect on the smooth muscle of the uterus in pregnant animals and presumably in man, might have a similar effect on the gastrointestinal tract. His prescription is as follows:

Tablets Pranone (Schering) five mg., #10.
Sig: one-half tablet twice a day.

If no relief is obtained after 10 tablets have been administered, the medication is discontinued. If relief occurs, which happens in about 70 per cent of cases, the medication is continued.

Dr. Joseph H. Fries*, in his study of gastrointestinal allergy in children, uses a mixture of equal parts of elixir of phenobarbital (USP) which contains one-quarter grain (15 mg.) per teaspoon, and Elixir of Dexedrine Sulphate (SKF), an N. F. preparation which contains one-sixteenth grain (four mg.) per teaspoon. The drug is best administered by a medicine dropper directly on the tongue before

*Personal communication.

feedings. The dose, which is governed by the effect, is one-quarter to one tsp. every four hours as necessary. In two infants the use of this preparation caused great excitement, but, in general Dexedrine is said to be well tolerated without excitement in infants and also in older children as indicated by the report of Roberts.²⁶

For severe colic, which does not respond to the above methods of treatment, I now use when necessary, with highly satisfactory results, Elixir of Demerol (Winthrop Laboratories). This contains 50 mg. of Demerol per teaspoon and is often effective in doses of five drops. It is very rare that more than one-quarter teaspoon is required. The dose may be repeated every four hours as necessary. Dr. Frederick J. Martin*, who has made a study of the dosage of Demerol in colic, recommends a dose of 1.0 to 1.5 mg. per kg. of body weight as a single dose.

Celiac Syndrome

Probably the next most important disease from the standpoint of allergy with respect to the frequency of incidence is the celiac syndrome. Andersen and diSant'Agnese¹ have described the celiac syndrome as a clinical picture characterized by chronic indigestion and failure to gain weight normally during infancy or childhood. The indigestion results in the excretion of bulky, foul stools, containing undigested starch, fat, and visible food fragments sometime during the course of the disease. There is chronic or intermittent diarrhea with intervening periods of constipation. The patient develops a "celiac" habitus with a protuberant abdomen, weak flabby muscles, and some degree of wasting.

The term "celiac syndrome" is used in preference to celiac disease because the clinical picture may have a varied etiology. For a discussion of this, reference is made to their original work. There is unfortunately no specific laboratory test by which celiac disease can be diagnosed. This discussion will be limited to the celiac syndrome of allergic origin. Kundstadter²⁸ and McKhann and associates²³ were the first to show that the celiac syndrome could be a manifestation of gastrointestinal allergy to food. They demonstrated the allergic nature of certain cases by successful treatment from the standpoint of allergy. The most important single therapeutic measure was the elimination of cow's milk in the diet, although occasionally it was found that foods other than cow's milk play an important part. In 1953, Kundstadter and Schultz²⁰ reviewed 36 cases of infantile diarrhea presenting the celiac syndrome and found that 11, or almost one-third, were of allergic origin, with cow's milk the principle offender. In most instances the infants were able to tolerate the reintroduction of cow's milk to the diet without resulting

diarrhea after an abstinence period of from three to 42 months (average 18.3 months), usually at the age of 30 months.

The evidence that other foods may cause the allergic celiac syndrome is steadily mounting. Collins-Williams and Ebbs⁸ found that the gluten of wheat starch was a relatively frequent offender. European investigators, particularly, have confirmed the importance of cereals, especially wheat, in producing the celiac syndrome. Weijers and Van de Kamer,³⁶ in Holland, studied wheat as the cause of celiac disease and state that it is the gliadin fraction which causes the difficulty.

As in most gastrointestinal diseases of allergic origin, skin tests are of little or no help in determining the etiological factors. It is my practice, with a patient suffering from any syndrome which may possibly be due to food allergy, to try an elimination diet.* Startlingly favorable results may occur within a period as short as 24 to 48 hours although occasionally a week or 10 days may be required to determine the effect of the diet. If by means of such diets the disorder is shown to be due to allergy to food, the diet may then be cautiously enlarged by adding one new food every four or five days until the offending food or foods are discovered.

As emphasized above, allergy is only one of the many causes of the celiac syndrome, but, since it is one of the easiest to rule out, this should always be considered when one is encountered with this problem.

There is little doubt in the minds of allergists but that chronic ulcerative colitis of the idiopathic type may be due to allergy. In recent years, the psychosomatic aspects of this disease have been so over-emphasized that one now tends to forget that other origins are possible. The fact that food allergy could be the cause of ulcerative colitis was pointed out by Andresen in 1925.² Almost always the cases of ulcerative colitis which reach the allergist, and that has been my experience in the majority of these studied personally, are patients suffering from irreversible changes in their bowels which cannot be helped, if any help is possible, by any means other than surgery. The time to study the allergic etiology of ulcerative colitis is as soon after the disease starts as possible. It cannot be too strongly emphasized that the best results will be obtained when the study from the standpoint of allergy is made very early in the course of the disease and not after months or years of treatment by the orthodox methods of gastroenterology and psychiatry have failed and the patient is presented to the allergist as a last resort after irreversible changes have taken place in the bowels. The same is perhaps true, though to a lesser

*Personal communication.

*See references (28) and (14) for details of such diets.

degree, of regional enteritis.³⁵ It is a very simple thing to place a child or adult with a persistent inexplicable diarrhea on an elimination diet for a few days early in the course of the disease, and this is something which should always be tried in such cases.

Before closing this discussion, it is well to mention that one of the fairly frequently encountered and usually asymptomatic manifestations of gastrointestinal allergy is the geographical tongue. About the only value the diagnosis of this condition has is that it indicates that one is dealing with an allergic patient. Aphthous stomatitis may occasionally be caused by food allergy, but in most instances the etiology is never determined. It must be distinguished from herpetic stomatitis. The differential diagnosis of these two conditions is beyond the scope of this presentation. For a consideration of this, reference is made to the work of Blank and associates⁵ and Stark, Kilbrick and Weisberger.³²

Pylorospasm has been occasionally caused by food allergy and mistakenly diagnosed as hypertrophic pyloric stenosis.³ It is quite possible that hypertrophic pyloric stenosis may in some way be related to allergy, but there is no proof of this etiology which is highly conjectural. Cyclic vomiting is now a disease which is rarely encountered. There is no doubt, however, but that an occasional case may be of allergic origin.¹¹ This, however, is a symptom complex of varied etiology, and most of the cases referred to me for study from the standpoint of allergy have been found to be due to other causes.¹⁶ It must not be forgotten that anaphylactoid purpura, an allergic reaction due in most instances to infection and sometimes to drugs and foods, may also produce severe gastrointestinal manifestations. Urticaria may occur in the intestinal wall as well as in the skin and some cases of intussusception are due to this cause.

Summary and Conclusions

A great variety of disorders of the gastrointestinal tract may have an allergic etiology. In many instances food allergy can be demonstrated as the cause. Skin testing is ordinarily not helpful, and elimination diets are the most practical method for making the diagnosis. The most common foods, milk, wheat, and eggs, are the most common offenders.

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Biliary Surgery

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DISEASE OF THE GALLBLADDER with its concomitant stones has been and continues to be one of the most common major surgical problems. With the advent of antibiotics, modern anesthesiology, and a better understanding of body chemistry, some changes have occurred in the management of biliary disease in the past few decades. This report is a review of 289 surgical procedures of the biliary tract, chiefly cholecystectomies, in private patients over the period 1945-1955, and discusses some of our methods.

Of the 289 operations, 276 were cholecystectomies, five choledochostomies, four cholecystostomies, three cholecystogastrostomies, and one cystic duct syndrome. It is to be pointed out that in this series of cases only four cholecystostomies were done, and one of these was done for carcinoma and another for acute pancreatitis. The two done for acute cholecystitis were in poor risk patients, and even then a partial cholecystectomy was carried out. In the past, cholecystostomy has been a favorite operation for the treatment of biliary disease, but now cholecystectomy is the operation of choice when possible. This definite change has come about because of our improved methods and the fact that many patients after cholecystostomy would find it necessary at a later date to be subjected to a cholecystectomy. Better understanding of the physiological make-up of the individual, such as his electrolyte and fluid requirements, as well as blood replacement, antibiotics, and modern anesthesia, has made the more radical approach feasible. Cholecystostomy still has a place, of course, in the aged or debilitated patient whose condition might not withstand excision of the gallbladder and might be a life saving procedure. It should not be dismissed from our armamentarium entirely but should be reserved for such cases as mentioned above.

Three cholecystogastrostomies were done for carcinoma of the head of the pancreas. Five common ducts were explored in jaundiced patients as a primary operation. Three of these were for residual common duct stones. Another was found to have a kinked common duct from adhesions following cholecystectomy many years before, and the fifth developed a stricture of the common duct following

exploration of the duct at the time of cholecystectomy two years previously. We encountered one cystic duct syndrome which was diagnosed by x-ray preoperatively. This patient had continued to have symptoms for six years following cholecystectomy. Exploration revealed a large calculus in a long cystic duct stump. We recognize the possibility of the cystic duct syndrome. However, we ligate the cystic duct about one quarter of an inch from the common duct. We feel that it is important to leave only a short cystic duct remnant but we avoid ligation flush with the common duct. This prevents injury to the common duct and lessens chance of subsequent stricture formation. We further believe in exact anatomical dissection and do not sever or ligate any structure until it has been completely identified.

Our series concurs with most other such series in the age and sex distribution. We had 244 (84 per cent) females and 45 (16 per cent) males, or a ratio of five to one. The old saying of, "Female, fat, flatulent and forty," is again shown by our figures. Although gallbladder disease can occur at almost any age, the majority of patients seen are between 40 and 60. Our youngest patient was 17 and our oldest 85 years of age. (Figure 1)

Two hundred fifty-three, or 88 per cent, of our cases were chronic; while 36, or 12 per cent, were acute. In all of the acute cases, except for the two cholecystostomies mentioned above, the gallbladder was removed with but one death, and that due to almost complete obliteration of the biliary tree from severe cholangitis. We feel that although each case has to be individualized, in general, acute cholecystitis should be considered a semi-emergency. If the diagnosis has been made within 72 hours, preferably 24 to 48 hours after the attack, we feel that surgery should be undertaken because of the unpredictable course of the disease. Gangrene with perforation and peritonitis is said to occur in five to 10 per cent of cases of acute cholecystitis, and in this series there were three perforations, or eight per cent.

The patient should first be prepared properly with fluids and antibiotics, and thoroughly evaluated. Maingot¹ has stated that 48 hours is the critical period, and either resolution will follow with disimpaction of the stone or complications will ensue. Even when the patient is seen 72 hours after the

Presented at the 106th Annual Session of the Medical Association of Georgia, Atlanta, May 13-16, 1956.

A Ten Year Review of Private Cases

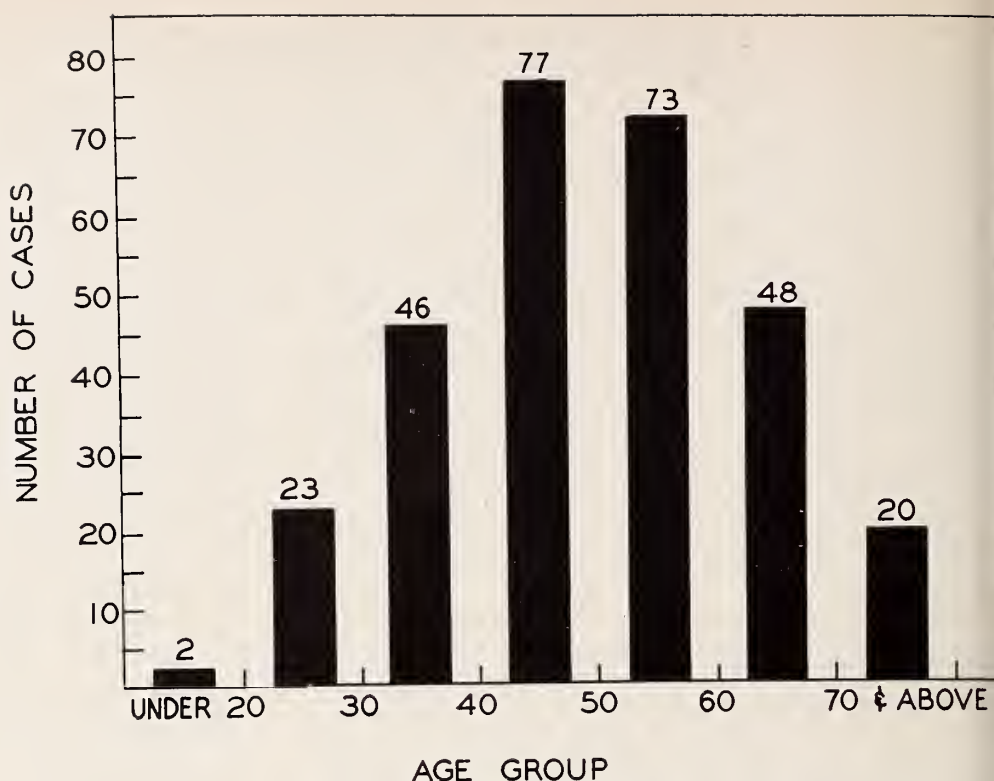


Figure 1

attack we feel that early operation is still indicated. Several days of expectant treatment may be carried out, and if the patient continues to improve, an elective operation can be done. If, however, while under observation, the patient's temperature climbs, the pulse rate quickens, the white blood count increases, or toxemia appears, gangrene with impending perforation will make surgery mandatory. We do not feel that, except in certain cases, the prolonged "cooling off" process is justified, as it takes many weeks for the tissues to return to normal and actually the technical aspects of the surgery could be more difficult at this time.

Of the 253 cases of chronic cholecystitis, 221, or 87 per cent, had associated stones. All of these patients had pre-operative cholecystography except eight who had been diagnosed at laparotomy during pelvic surgery. It is generally accepted, and we concur, that very seldom is there indication for removal of a gallbladder unless it contains stones. However, in five to 10 per cent of cases, small stones can be hidden by the dye and x-rays should be repeated in cases where symptoms continue. We have used the double dose technique frequently and always repeat with this method if the first x-rays return as "non-functioning" gallbladder.

The common duct was explored in 45 cases, or 16 per cent, and stones were found in 13 instances, or 29 per cent. Forty, or 14 per cent, were explored at the time of cholecystectomy and stones were found in 10 cases, or 25 per cent. The following indications were used for exploration of the common duct:

1. Jaundice, present or past..... 14
2. Multiple small stones and patent cystic duct with history of colic..... 14
3. Dilated common duct..... 13
4. Sediment in aspirated bile..... 4
5. Stones palpated in thickened duct..... 3

The other five common ducts explored as a primary operation have been discussed above.

As can be seen from the number of ducts explored, we do not hesitate to do this procedure but are not as radical as some who have advocated routine choledochostomy in the presence of cholelithiasis. If the clinical findings can be explained on pathology found at the operating table and no indications are noted for exploring the duct, we have not done so. Our only morbidity from exploring the duct in the 40 cases was a subsequent stricture of the common duct at the site of the T-tube two years after exploration.

We have done only a few operative cholangiograms, but these have been an aid in making the decision as to whether or not a duct should be explored. Operative cholangiograms also would lower the necessity of duodenotomy in many cases. At times it is extremely difficult to pass an instrument of any type into the duodenum through the common duct because of spasm of the sphincter of Oddi. This worries the surgeon considerably; there is the fear of overlooking a stone in the distal duct. Flushing of the duct will frequently give the answer, but in some cases there is still uncertainty. An operative cholan-

giogram has been beneficial to us at this point. Although we have done five duodenotomies, we feel that it carries a definite risk in morbidity, and we prefer not to open the duodenum unless it is absolutely necessary.

All common duct explorations are followed by insertion of a T-tube. The T-tube is left in place for varying lengths of time depending upon each case. The earliest one was removed on the third day because the tube was obstructed, and the longest time a T-tube was left in was 18 months, but the average time is 10 to 14 days. Prior to removal of the tube, a cholangiogram is always made. It has been our experience that spasm of the sphincter of Oddi will frequently cause a deformity on the cholangiogram at the sphincter simulating a stone. We "sweated out" four of these until we began to administer 1/100 of a grain of nitroglycerin under the tongue just prior to the cholangiogram. This relaxes the sphincter, and the contrast media will flow easily into the duodenum.

The type incisions we have used have been mostly subcostal or transverse. These incisions are particularly indicated in the obese individual where many times the tissues are poor and it is easier to close simply by "breaking" the table and flexing the abdomen. The incidence of hernia is less, and the patient is more comfortable in the post-operative period. However, a paramedian incision has been employed in some cases, chiefly thin individuals, and gives good exposure. We feel that an operation is easy if you can but get to it, and try to individualize each case. Almost all of these cases have had antibiotics, chiefly penicillin, for at least three to six days post-operatively. The anesthesia has been general and spinal, but our preference is spinal as it gives relaxation par excellence, and we have had no neurological post-operative residuals.

We have had three cases of adeno-carcinoma of the gallbladder, one case of adeno-carcinoma of the ampulla of Vater, and one case of carcinoma of the biliary ducts. None of the carcinomas of the gallbladder were jaundiced pre-operatively, and each had a non-functioning gallbladder by x-ray. The other two cases were jaundiced pre-operatively. None of these patients lived more than six months following surgery, and two died before leaving the hospital.

Despite our miracle drugs, early ambulation, and other methods, we still have morbidity following biliary surgery. In this series we had 30 cases, or 10 per cent, with 33 morbid conditions.

1. Ileus	10
2. Atelectasis	8
3. Hiccoughs	3
4. Subphrenic cellulitis	2

5. Thrombophlebitis	2
6. Phlebothrombosis	1
7. Evisceration	1
8. Strangulated hemorrhoids	1
9. Post spinal headaches	1
10. Temporary duodenal fistula	1
11. Mental confusion	1
12. Coronary thrombosis	1
13. Respiratory depression	1

Ileus (10): All of these cases were treated by gastric suction and responded quickly to treatment. We have not routinely used post-operative gastric suction in all cases as is advocated by some, and the low rate of three per cent we think justifies this. In some cases prior to removal of the Levine tube, two ounces of castor oil were administered; we feel that this decompresses the bowel further and helps considerably.

Thrombophlebitis (2) and *Phlebothrombosis* (1): These were all typical cases and were treated with anticoagulants and wrapping of the legs. We did no vein ligations on these cases.

Atelectasis (8): This continues to be a troublesome complication despite early ambulation and the so-called stir-up treatment. All of our cases have been lobular in type, and we have had no massive atelectasis. We encourage deep breathing immediately post-operatively and continue this for several days as well as getting the patient up and moving as soon as possible. Antibiotics have unquestionably helped in this complication a great deal.

Subphrenic cellulitis (2): Two cases had a definite subphrenic involvement. One followed removal of an acutely inflamed gallbladder, while the other came on after removal of a chronically diseased gallbladder with stones. Both of these cases ran an intermittent high fever for five to six days which subsided with antibiotics. We routinely drain all gallbladder cases by placing a Penrose drain in the foramen of Winslow, and in severe cases also drain Morrison's pouch. We do not feel that this type of drain can do any harm—indeed from the amount of drainage which we see in some cases, it has prevented a biliary peritonitis. The drains are usually removed in 48 to 72 hours if there is minimal drainage.

Hiccoughs (3): This is a distressing and uncomfortable complication. All of the conventional methods are usually attempted before the hiccoughing will finally cease. Thorazine did seem to be of definite benefit in one of these cases.

Other morbid conditions that we have encountered are: evisceration, strangulated hemorrhoids which necessitated insertion of a retention catheter, post-spinal headache, temporary duodenal fistula, mental confusion, coronary thrombosis, severe res-

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Biliary Surgery . . . (cont'd)

piratory depression, and one case was readmitted three weeks post-operatively with severe upper gastro-intestinal bleeding which was found to be originating from esophageal varices.

The death rate in surgery of the biliary tract depends largely upon the presence of complicating factors. In this series of 289 cases, there were eight mortalities, or 2.7 per cent. Of these eight deaths, seven patients were poor risk cases pre-operatively. One patient, Mrs. M., age 36, during a routine elective cholecystectomy had a cardiac arrest on the table. She was resuscitated but never regained consciousness and died 48 hours later from the effects of cerebral anoxia. Three of the deaths were in patients aged 64, 68, and 76 respectively, who were operated upon for carcinoma of the pancreas and carcinoma of the biliary tract. None of these did well post-operatively, and they succumbed on the fourth, seventh, and nineteenth post-operative days respectively.

There were two fatalities in patients who had severe cholangitis. Both of these patients were deeply jaundiced and acutely ill prior to surgery. Mrs. A., age 63, died on the twenty-second post-operative day. Autopsy revealed almost complete obliteration of the biliary tree from fibrosis of the ducts. Mrs. C, 52, was found to have a severe cholangitis from rupture of a duodenal ulcer into the common duct. A choledochostomy was done and the patient did fairly well for four days, then suddenly went into shock and died on the fifth post-operative day. Mrs. S., age 85, was deeply jaundiced and toxic and had innumerable stones in a markedly dilated and thickened common duct. She had a stormy post-operative course and on the tenth post-operative day eviscerated, went into shock. and died the next day. Mrs. T., age 74, died 29 days following exploration of the common duct with removal of small stones and considerable mud.

It can be clearly seen from these mortalities that the complications of biliary tract disease in the elderly are usually responsible for death. Cholecystectomy for gallbladder disease earlier in life might have prevented death in several of these cases.

Summary

1. Two hundred eighty-nine cases of biliary tract surgery in private patients are reported; of these, 276 were cholecystectomies.

2. Reasons are given why cholecystectomy has chiefly replaced cholecystostomy in the treatment of biliary disease.

3. In this series there were 244 females and 45 males, or a ratio of five to one. The majority of cases were between the ages of 40 and 60.

4. Two hundred fifty-three, or 88 per cent, cases were chronic whereas 36, or 12 per cent, were acute.

5. Reasons are given for treating acute cholecystitis as a semi-emergency, and early cholecystectomy is advocated.

6. The common duct was explored in 45, or 15 per cent, of the cases. Stones were found in 13, or 29 per cent, of those explored. The indications for exploring the common duct are given.

7. Cholangiograms are discussed, and the value of the administration of nitroglycerin prior to the x-rays is mentioned.

8. Morbidity is discussed as it pertains to this series. Post-operative ileus and atelectasis were the chief complications.

9. Eight deaths occurred giving a mortality rate of 2.7 per cent. With the exception of one case, all of the deaths were in elderly patients who had complications of biliary disease. Cholecystectomy earlier in life to prevent complications is advocated.

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Kidney Stones—New Horizons

NO UROLOGIST IS SATISFIED with the current treatment of kidney stones. This dissatisfaction has led urological investigators to undertake experiments which hold great promise for the future understanding of the etiology of kidney stone formation.

A number of basic laboratory reports on protein, bone and calcium metabolism preceded the brilliant experiments of Baker¹, Boyce², Butt³, Prien⁴ and others⁵ who had suggested a common mechanism in the formation of most kidney stones. While the initial experiments paved the way for these investigations, it was left to the later investigators to develop a plausible theory of calculous disease. An abandonment of well established principles regarding this disease has not been suggested, but the investigators have subjected to critical analysis factors formerly accepted as primary agents in calculous disease. Such agents as the availability of calcium and phosphorus, climate, dietary, bed rest, and certain metabolic diseases related to the parathyroid have in the light of recent experiments been assigned a secondary role in the pathogenesis of stone disease.

In 1936 investigators showed that the precipitation of urinary colloids could be influenced by the administration of salicylates, but it was not until recently that scientists were able to understand the importance of this isolated laboratory report. Nor was the importance of protective colloids in the prevention of kidney stones clearly understood. The role of colloids in the pathogenesis of kidney stones was suspected but unproved. Laboratory studies pointed to the renal tubular connective tissue matrix or ground substance as the site of primary disease—the *target area of the stone problem*. Dysfunction of this *target area* or ground substance, reasoned the investigators, resulted in an alteration of hyaluronic acid, a protective colloid and a substrate of the enzyme hyaluronidase. Subsequent experiments revealed the result of a reduction in the quantity of the mucopolysaccharide hyaluronic acid or its related substances glucuronic acid and glucosamine would result in an interference with the transportation and solubilization of so-called crystalloid substances. This defect could be overcome, so Butt stated, by the subcutaneous administration of optimum doses of the enzyme hyaluronidase. This enzyme caused an increase in urinary glucuronic acid and possibly an increase in urinary hyaluronic acid. Should this sequence of events actually occur, calculus formation

should be prevented. The results of these preliminary experiments were encouraging indeed and established certain important fundamental data. However, much of the work has not been repeated and the conclusions have not been generally accepted.

The independent classic experiments of Baker, Boyce, and Prien previously referred to, establish a relationship between renal calculous disease and stress. Under certain conditions of stress, the protein-sugar substrates of the renal tubule connective tissue matrix not only have the ability to provide the framework of calculi, but may even determine the nature of the crystalline structure by extracting specific components of urine from solution. These experiments, repeated by several independent investigators, suggest that kidney stone formation is another of the collagen system diseases. The connective tissue matrix of the kidney tubule, a part of the collagen system, undergoes changes not unlike the changes which occur in other areas of the body under similar conditions of stress. This concept that urolithiasis is a general systemic disease due to an alteration of tubular connective tissue is now accepted by many investigators. Divergent views exist, but are more the result of differences of interpretation of observations than disagreement over fundamental concepts.

It is generally accepted that urinary crystals coalesce under the influence of an ion-binding mucopolysaccharide of great molecular weight. This mucopolysaccharide must arise from the tubular *target area* inasmuch as its molecular size is too great to have permitted passage through the glomerular membrane. Since this sugar-protein compound is present in the urine in renal calculous disease, it must be a product of alterations of the renal tubule alone and subsequently jettisoned into the urinary stream under certain conditions.

The interest in urolithiasis research has been rather general. An interpretation of the basic mechanism involved has been proposed by the British investigator Carr.⁶ His laboratory studies suggested the involvement of the renal lymphatic system in the production of kidney stones. The normal drainage mechanism for removing embryonal stones or micro-liths is apparently the renal lymphatic system. When this drainage mechanism breaks down and the evacuation of nuclei is prevented, calculi develop. While this is an interesting anatomical study, it has failed to explain the initiating factors involved in this bizarre disease.



Sufficient evidence has been accumulated to substantiate the findings of Baker, Boyce, and Prien, namely that kidney stone formation is one reflection of a general systemic disease of the collagen system. In the kidney the *target area* is the tubular connective tissue matrix. If, as these investigators suggest, the disease is one of stress, the logical approach to therapy would be in the direction of anti-stress or anti-rheumatic drugs. The use of salicylates, cortisone, and related compounds for the prevention of kidney stones is the natural outgrowth of these fundamental research efforts. An objective evaluation of this avenue of therapy in the treatment of kidney stones is anxiously awaited.

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Social Security—Pro and Con

DURING THE PAST FEW MONTHS, three articles have appeared in the *Journal of the American Medical Association* and one in *Medical Economics* on various aspects of Social Security and the question of participation in the program by the medical profession. In spite of these and many other articles there still remain many unanswered questions among doctors as to just what this program offers and what would be its cost.

Under the present law, Social Security offers two types of protection: Survivors' Benefits and Retirement Benefits. The first provides monthly payments to surviving widows with children under 18 years of age. The latter protection, Retirement Benefits, provides for monthly payments to both man and wife upon reaching a certain age. This age at present is 65 years for men and 62 years for women. There are many other stipulations and limitations under the terms of both the Retirement Benefits and the Survivors' Benefits which will not be considered in this brief account. When these are considered, together with the types of payments and the possibility of further changes in the law, there is much grounds for confusion and indecision. For any doctor to completely understand the Social Security program it would be necessary for him to devote considerable time and then be quite confused by the mass of information acquired. Two of the recent articles appearing in the *JAMA* have been definitely

opposed to Social Security for doctors and quite outspoken in this opposition. To get that side of the picture it is recommended that these articles be examined.^{1 2}

This year two national polls have been taken among doctors. One is reported in *JAMA*³ and the other in the September 1956 issue of *Medical Economics*. In both polls, the doctors indicated that they did not favor Social Security on a compulsory basis. In another poll taken among the doctors of Georgia, the results indicate a desire of physicians to be included under Social Security on a voluntary basis but not on a compulsory basis.

Much has been written in medical publications against physician participation in Social Security. In an effort to balance this controversy, some of the points in favor of Social Security will be outlined here.

1. There is opposition to a compulsory Social Security program for doctors. Before making a decision on this point physicians should be aware of the fact that they are already financing a significant portion of this program under our existing federal tax structure. Every purchase is being taxed to subsidize Social Security. Up to four per cent of the cost of any purchase may be used as Social Security tax. Doctors are already paying for a considerable portion of the program without realizing any benefits.

2. Old Age Survivors' Insurance is the cheapest form of insurance protection yet devised. From discussing this point with members of the insurance industry it has been learned that this coverage is equivalent to a \$25,000 policy for a man between the ages of 30 and 50 years. To purchase this coverage from regular insurance sources would cost \$325-\$450 per year premium. The direct cost to physicians of all ages to be included under Social Security is at present \$126 per year. This will increase over the next 19 years to slightly over \$250 per year. At the higher figure it might still be a good buy.

3. Survivors' Benefits offers protection to the families of younger physicians which could only be purchased at a considerably higher figure. Under maximum benefits, Social Security protection can be equivalent to a \$50,000 estate.

4. Physicians now constitute the only occupational group not covered under Social Security. Nevertheless, we are paying a considerable portion of the cost. In the early days of the program many professional groups were much opposed to it and refused to participate. These included bankers, lawyers, and many members of the insurance industry. All of these have now come under the program, and it is generally considered to be a significant addition to their over-all insurance protection.

Most doctors adhere to the principles of private enterprise and the concept of freedom of choice. The Social Security program may well be considered as diametrically opposed to these fundamental concepts. However, it seems certain that the program is here to stay. All other occupational groups are now included as potential beneficiaries under Social Security. Before making a final decision on this matter each of us should seek advice of our insurance counselors. We should have mature advice before determining whether or not we should be included in the Social Security program even on a compulsory basis.

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Georgia and A.M.E.F.

A HOUSE COMMITTEE of the United States Congress has mailed a questionnaire to most medical organizations relative to federal aid to medical education. The implications of this questionnaire are apparent to all of us.

As you know, the American Medical Education Foundation was organized and sponsored by the American Medical Association in 1951 to seek financial contributions in behalf of the medical schools. The medical profession's annual goal is \$2,000,000 and this sum is needed in addition to funds contributed annually from other sources. Industry and business are asked to assist in raising the additional amounts to meet the annual \$10,000,000 operational deficit of our medical schools. Unless we reduce this deficit, the practice of medicine as we know it today will no longer exist.

In 1955 the A.M.E.F. disbursed \$1,120,000 to the medical schools. Since 1951 the total forwarded by the Foundation has been \$4,684,312. Together with contributions from industry collected through the National Fund for Medical Education \$9,598,491 has been made available to the schools since 1951.

The fifth annual report of the Foundation shows that 55 Georgia physicians contributed to the Foundation in 1955. During the same period 271 Georgia physicians made financial contributions totaling

\$5,774.00 directly to the alumni programs of their own schools.

These statistics prove conclusively that our physicians need to be educated to the pressing financial need that exists in our medical schools, and my appeal this month is directed to those members of the profession who have not yet given their financial support either to the American Medical Education Foundation or to the medical schools from which they graduated.

By contributing to the A.M.E.F. the medical profession is factually stating its depth of conviction in the present character of our medical schools. Additional solid response from our profession will stimulate a like response from business and industrial groups. Dr. Louis H. Bauer, A.M.E.F. President, points out, "As long as our institutions of higher learning remain free from Federal subsidy and control, the future freedom of this nation is assured and the rights of the individual protected."

The A.M.E.F. campaign this fall will be a success in Georgia if we reach our quota of \$10,000.00. We hope you will make your contribution immediately since our drive ends December 31, 1956.

In the period January 1, 1956 through October 31, 1956, Georgia contributed \$1,834 to the American Medical Education Foundation. Of this amount, various woman's auxiliaries contributed a total of \$1,444; county medical societies contributed \$103; and individuals contributed \$217. The contributors are listed below:

Kenneth L. Buresh, Coumbus; H. G. Byrd, Athens; George D. Dorian, Warm Springs; Frank R. Mann, Jr., McRae; A. P. Keller, Jr., Athens; C. H. Richardson, Jr., Macon; W. M. Gilbert, Rome; W. G. Elliott, Cuthbert; W. L. Pomeroy, Waycross; Goodloe Y. Erwin, Athens; H. Dawson Allen, Jr., Milledgeville; Eli A. Rosen, Dalton; Habersham County Medical Society; Worth County Medical Society; the woman's auxiliaries to the following county medical societies: Baldwin, Bibb, Bulloch-Candler-Evans, Cherokee-Pickens, Cobb, Crisp, Dougherty, Erwin, Fulton, Georgia Medical Society, Habersham, Muscogee, Richmond, Sumter, Thomas, Upson, Ware, and Worth; and the Woman's Auxiliary to the Medical Association of Georgia.

Remember, your contribution is tax deductible and you may designate the school of your choice.

SPECIAL ANNOUNCEMENT

CREATION OF AN ORGANIZATION known as the "Association of Grady Residents" is underway. Every physician who has completed an appointment as a resident or intern on any service at Grady Memorial Hospital is urged to join.

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Mr. Forhert speaks on typography.



"The Role of the State Medical Journal"—Dr. Smith



Mr. McKenzie—"Cover Design"

ON NOVEMBER 3 AND 4, 1956, the *Journal of the Medical Association of Georgia* sponsored the Southeastern State Medical Journal Conference at the Academy of Medicine in Atlanta. In attendance were 35 representatives of 13 state journals and one county bulletin from the Southeast and surrounding states. The state journals represented were those of the following states: Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Missouri, North Carolina, Oklahoma, South Carolina, Texas and Virginia. Special guests were Mr. Alfred J. Jackson, Mrs. Adelaide K. Davis, and Mr. Earl A. Sorensen, of the State Medical Journal Advertising Bureau, Chicago.

The meeting convened at 1:45 p.m. Saturday afternoon, November 3rd, with Edgar Woody, Jr., Editor of the *Journal of the Medical Association of Georgia*, presiding. On hand to welcome the conference participants in behalf of the Medical Association of Georgia were Hal M. Davison, President, and David Henry Poer, Secretary of the MAG and Editor-in-Chief of the *Journal*.

Austin Smith, of Chicago, Editor of the *Journal of the American Medical Association*, got the meeting off to a flying start with his talk on "The Role of the State Medical Journal." A lively discussion period followed Dr. Smith's presentation. Dr. Smith was again heard on Sunday when he spoke on "The Journal as a Team Operation."

Mr. Otto M. Forkert, also of Chicago, President of O. M. Forkert and Associates, conducted individual typography counseling sessions on Saturday morning and Sunday afternoon besides addressing the group assembled on typography. Mr. Forkert is a nationally known consultant in the graphic arts, design, and typography and worked with the state



Journal Conference—Atlanta

medical journals at the biennial meeting sponsored by the State Medical Journal Advertising Bureau last November.

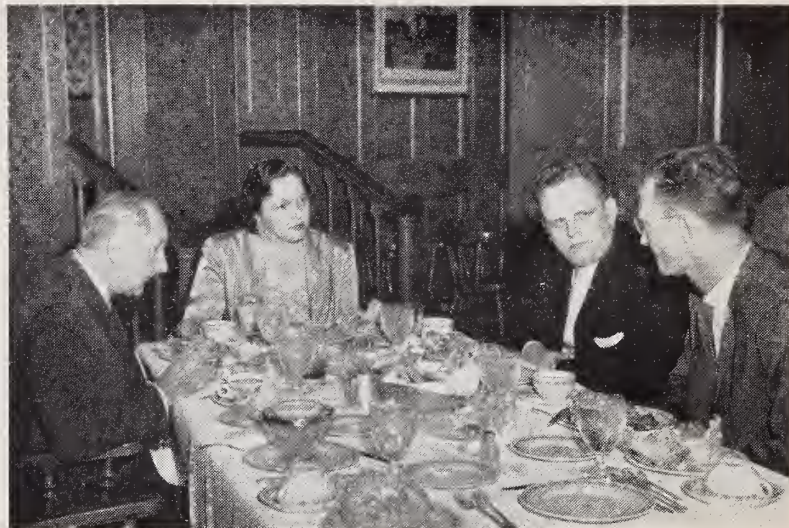
"Cover Design and the Use of Illustrations" was discussed by Mr. John Stuart McKenzie, design consultant with the Higgins-McArthur Company of Atlanta, and Ted F. Leigh, *Journal* Photography Editor. Mr. McKenzie presented the elements of good design for covers, and Dr. Leigh told how some of the covers that have been used on the *Journal* were created.

Mrs. Ethel M. Liebscher, Director of Research and Assistant to the President of Burke Dowling Adams, Inc., advertising agency, gave the journal representatives tips on methods of obtaining more local advertising. This is a field which has been sadly neglected because of the large number of ads gotten so effortlessly on our part through Mr. Jackson and the staff of the State Medical Journal Advertising Bureau.

Mr. Albert Beehler, vice-president of Waverly Press, Baltimore, Md., and Mr. McKenzie spoke on "Selection of Printer." Mr. Beehler was also a member of the panel to discuss and answer questions on journals in general; other members were Mr. Forkert and Mr. McKenzie.

On Saturday night, de Leon Laboratories of Atlanta, Mr. Harold C. "Red" Palmer, president, sponsored a social hour and dinner for all conference participants and guests at the Piedmont Driving Club. This informal gathering was one of the highlights of the meeting.

This is the first such regional conference for state medical journals ever held; if demand warrants a repeat performance, there will be another Southeastern State Medical Journal Conference in 1958.



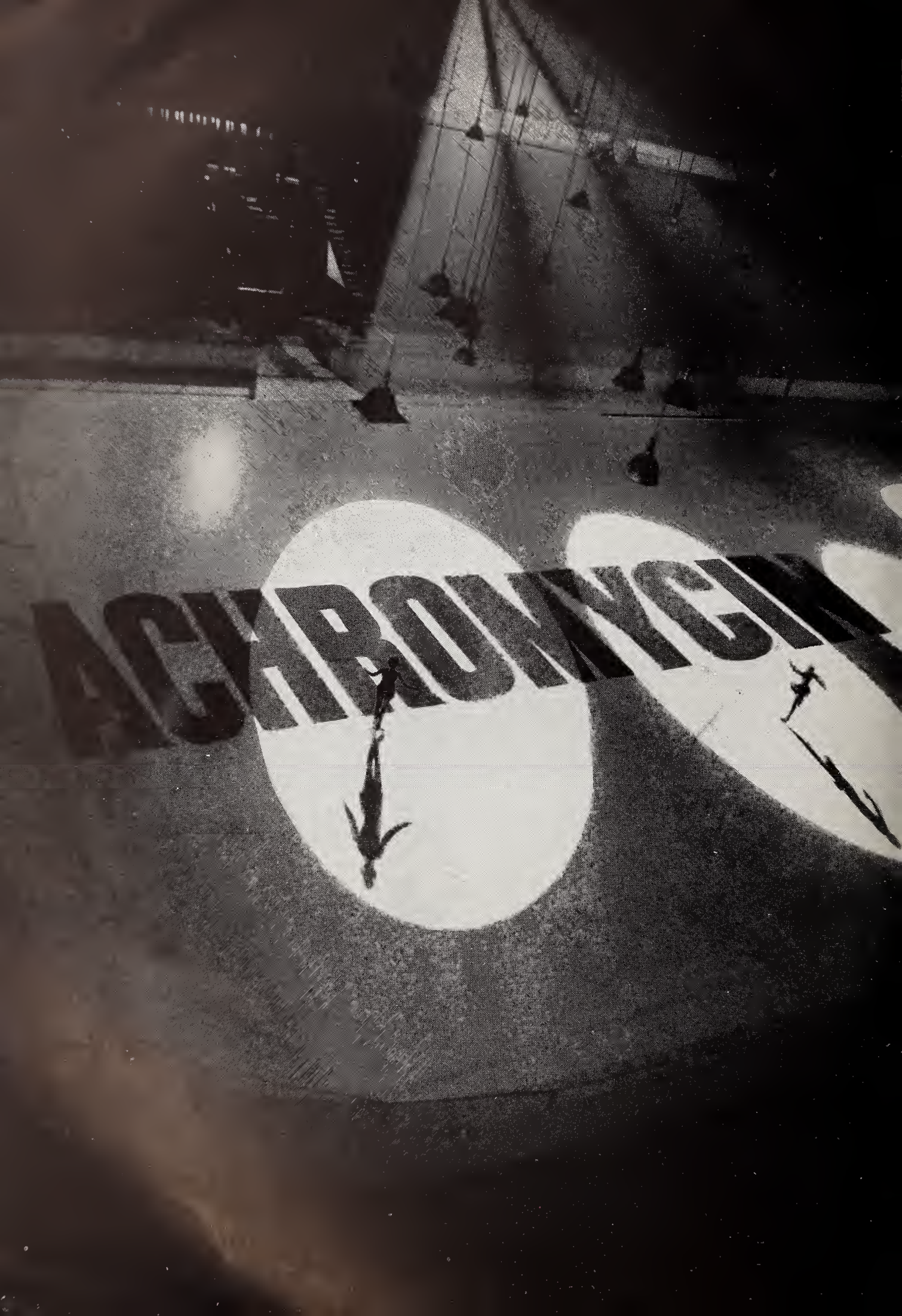
Mr. Forkert, Mrs. McKenzie, Mr. McKenzie and Mr. Nance



Dinner Saturday night was sponsored by de Leon Laboratories, Inc., Atlanta



Dr. Clagett, Miss Porcher, Dr. Jones, Dr. Smith, Mrs. Woody and Dr. Wood



ACHROMYCIN*

Hydrochloride
Tetracycline HCl Lederle

in the treatment of

genitourinary infections

UROLOGISTS report the decided advantages of oral efficacy, minimal side effects, and wide range antibacterial activity offered by ACHROMYCIN in the treatment of urinary tract infections.

Finland's¹ group of patients with acute infections of the urinary tract (principally *E. coli*) demonstrated excellent response, both clinical and bacteriological, following administration of tetracycline.

Prigot and Marmell² reported 49 out of 50 patients with gonorrhea showed a negative smear and culture on the first post-treatment visit. Purulent discharge disappeared in these patients within 24 hours after a usual 1.5 Gm. dose of tetracycline.

Trafton and Lind³ found tetracycline (ACHROMYCIN) an effective antibiotic for treating many urinary tract infections caused by both Gram-negative and Gram-positive organisms.

English, *et al.*⁴ noted that a daily dose of 1 to 1.5 Gm. of tetracycline resulted in urinary levels as high as 1 mg. per milliliter.

To suit the needs of your practice and to further the patient's comfort ACHROMYCIN is offered in a complete line of 21 dosage forms.



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References:

1. Finland, M., *et al.*: *J.A.M.A.*, 154:561 (Feb. 13) 1954.
2. Prigot, A. and Marmell, M. *Antibiotics and Chemotherapy* 4:1117 (Oct.) 1954.
3. Trafton, H. and Lind, H.: *idem* 4:697 (June) 1954.
4. English, A., *et al.*: *idem* 4:441 (April) 1954.

abstracts by georgia authors



Shek, John L.; & Raymond F. Corpe, Battey State Hospital, Rome, Ga. "Comparative Study of Postresection Morbidity in Cases with and without Preresection Thoracoplasty" *J. Thoracic Surg.* 32:92-95 (July) 1956.

In the patients receiving a preresection thoracoplasty there were 18 patients with complications (18 out of 65—28 per cent). Of the 70 patients without preresection thoracoplasty, 30 had complications (30 out of 70—43 per cent).

The complications studied were (a) difficulty in expectoration, (b) evidence of prolonged air leak, (c) poor re-expansion of lung, (d) bronchopleural fistula, and (e) empyema.

Of the patients with a preresection thoracoplasty, 15 of the 29 complications were difficulties in expectoration, the mildest form of complications studied. Ten complications were either evidence of prolonged air leak or poor re-expansion of lung occurred.

Of the patients without a preresection thoracoplasty, eight of the 53 (17 per cent) complications were difficulties in expectoration while 39 (74 per cent) were due to poor re-expansion of lung or prolonged air leak.

A review of the complications following segmental resections revealed practically no difference between the group with a preresection thoracoplasty and those without. In the lobectomy cases, complications occurred three times more frequently in the cases without preresection thoracoplasty.

Only one patient in each series developed an empyema and both were lobectomies.

Conclusion: A preresection relaxing thoracoplasty is of little value in segmental resections of the upper lobe in regard to reducing morbidity.

The postoperative course in upper lobectomies is much less complicated when a preresection thoracoplasty is utilized.

Further study is needed to really determine whether this additional operation is advisable, even in lobectomies, when one considers that no segmental resection had an empyema and only two lobectomies developed an empyema—one in each series.

Brown, J. H. U., Robert B. Smith, III, John B. Griffin, Atlanta Anason, and Julian Jacobs, Dept. of Physiology, Emory University, Ga. "Physiologic Activity of an Adrenocorticolytic Drug in the Adult Dog", *Metabolism* 5:594-600 (Sept) 1956.

Normal dogs were fed the adrenocorticolytic drug DDD at a level of 88 mgs./kg./day for periods of about three weeks. During the period of drug intake each dog was tested for adrenal cortical dysfunction by means of the insulin tolerance test, the eosinophil response to ACTH, the level of steroid excretion, and the signs of adrenal cortical failure. All dogs developed similar symptoms: the sensitivity to

insulin increased tenfold, the administration of ACTH failed to produce a decrease in circulating eosinophils, the excretion of adrenal cortical steroids in the urine decreased markedly, and the dogs developed muscular weakness, anorexia and other signs of adrenal failure. Administration of ACTH failed to correct the deficiency. Examination of tissues on autopsy revealed destruction of the adrenal cortex but no signs of drug toxicity in any other organ.

Fox, Vernelle, 41 Peachtree Place, N. E., Atlanta 9, Ga. "The Management of Acute Alcoholism", *Am. Pract.* 7:1461-1464 (Sept) 1956.

Tranquilizers have offered a major advance in the management of the symptoms of withdrawal from alcohol. In this study, 61 private patients seen in 75 admissions, over a 13-week period, were treated with promazine, a new member of the phenothiazine series, which possesses all the desirable pharmacological properties of chlorpromazine but lacks some of the undesirable side effects.

One or two, and occasionally three intramuscular doses of 100 mg. promazine, followed by an average of 16 oral doses of 100 mg. for maintenance, sufficed for almost all patients, regardless of the severity of the alcoholic symptoms. The average hospital stay was about three days; patients with delirium tremens or acute hallucinosis were able to leave in six days or less; 35 per cent of this series were brought through the withdrawal period without supplementary alcohol, and no patient required narcotics, intravenous fluids, prolonged use of restraints, or strong-room care.

All were relaxed and in good physical condition on discharge, with instructions to continue maintenance therapy. Twenty-one per cent entered immediately on a long-range rehabilitation program, or expressed a desire for further supportive psychotherapy.

Schubert, Joseph H.; Donald S. Martin, C.D.C. Public Health Service, Chamblee, Ga. "The Evaluation of Serologic Tests for Leptospirosis" *J. Lab. & Clin. Med.* 48:155-164 (July) 1956.

Comparative studies of the complement fixation test, the capillary agglutination and the microscopic agglutination technique were performed on sera from human, bovine, and the canine species. Sera from normal humans, sera from limited number of patients with infections other than leptospirosis, including homologous serum jaundice and infectious hepatitis, gave negative reactions with the three antigens.

The complement fixation antigen employed was a whole leptospira suspension which was stable and simple to prepare. It was suggested that the complement fixation test is practical for use by reference diagnostic laboratories confronted with the problem of processing large numbers of sera.

Godwin, John T., St. Joseph's Infirmary, Atlanta, Ga.; Robert E. Carroll and William L. Watson, Memorial Center for Cancer and Allied Diseases, New York, New York, "Osteogenic Sarcoma of Phalanx After Chronic Roentgen-Ray Irradiation" *Cancer* 9:753-755 (July-August) 1956.

This is a report of an osteogenic sarcoma arising in the distal phalanx of the thumb of a dentist. It occurred after many years of intermittent exposure to roentgen-ray irradiation while holding dental film in place during roentgenographic examination. The series of events in this case make it reasonable to assume that this is an example of postradiation osteogenic sarcoma.

The Junior League Speech School and the Georgia Vocational Rehabilitation Service will help him.

Jacobs, Julian; and J. H. U. Brown, Dept. of Physiology, Emory University, Ga. "Kidney Function in the Adult Rat", *Am. J. Physiol.* 186:172-174 (July) 1956.

Endogenous creatinine clearance of the adult rat has been determined to be 0.556 ml/min/100 gm B. W. This value must be increased about 25 per cent in order to obtain 'true' creatinine clearances. Large doses of atropine or hexamethonium decreased the creatinine, sodium and potassium clearances. The clearance of sodium was decreased to a greater extent than was the creatinine or potassium clearance. The urinary Na/K ratio was also decreased in the presence of both drugs.

Hoagland, Robert J., Col., M. C., U. S. Army Hospital, Fort Benning, Ga. "Cardiac Involvement in Infectious Mononucleosis", *Am. J. M. Sc.* 232:252-257 (Sept) 1956.

Cardiac involvement in mononucleosis is limited to the myocardium and the pericardium. Complicating, or subsequent, valvular heart disease can be dismissed as unproved.

Complicating pericarditis has been reported, but it occurs rarely. It has not been observed by the author in a series of almost 300 personally examined cases of serologically proved mononucleosis.

Because of conflicting reports of the frequency of electrocardiographic abnormalities, 100 consecutive cases of mononucleosis had electrocardiographic studies. Many patients had weekly tracings for three weeks. All met clinical, hematologic, and serologic criteria for diagnosis. Only five patients showed any electrocardiographic abnormalities; in at least one case the change was of questionable significance.

Reports of a greater frequency of electrocardiographic abnormalities are explained by: (1) selection of cases; (2) inclusion of cases which are not mononucleosis; (3) over-interpretation of trivial electrocardiographic changes.

There seems to be no more reason to fear cardiac involvement in patients with mononucleosis than physician-induced cardiac anxiety.

THE PATIENT'S RIGHT to know has been judicially passed on most often in cases growing out of surgery. I believe it is now the generally accepted conception that the patient should be advised clearly and not in technical terms of the nature and extent of his trouble, the risks involved, the consequences of not having the operation, and the possibility of other conditions' being found which may require operative procedure.

The right of the patient to know his trouble is a corollary of the precaution which the surgeon should take in obtaining proper permission to proceed with surgery. When the preoperative study has been made and a decision to operate reached, it would seem to me that this would be a proper time to make both the full disclosure to the patient of his trouble and to obtain his consent to proceed with the surgery—including permission to take care of other conditions which may be found and which in the judgment of the surgeon may require operative procedure.

If the consent form for the surgery were submitted to the patient at the time of the disclosure it would tend to emphasize in the recollection of the patient the fact of the disclosure, make it easier to obtain the consent, and furnish the necessary written proof that both disclosure and consent had been made and given if question about it should thereafter be raised.

Between the physician and the patient there exists a relationship of trust and confidence. While generally there is a duty to inform the patient, there may be situations in which the surgeon may be justified in withholding specific information; either great shock may be caused or it may be considered bad therapy to disclose the exact diagnosis. After a malpractice suit or two, however, the surgeon may come to the conclusion that the most delicate approach possible should be made in informing the patient, hoping for a minimum effect from shock, if any. Even if therapeutic considerations prevail and disclosure is not made to the patient, the true facts should be told to his immediate family; and unless there is a long and cordial relationship between the family and the physician, the written consent of one or more of the next of kin should be obtained.

The physician always runs a risk in failing to tell the patient of the possible consequences of an operation. If it should fail to turn out to his entire satisfaction or that of his family, the doctor subjects himself to suit and recovery of damages. In a Canadian court a woman had a swelling in the palm of her

right hand and submitted to an operation; her surgeon did not disclose to her the probability of a poor result. The patient had Dupuytren's contracture, and if she had known of the odds of failure, she testified when she sued the doctor, she would not have consented to the operation. The operation was skillfully performed, but the patient was left with a greater disability than she had when she first consulted the surgeon. When the case was tried it was shown that the operation was performed with great expertness; nevertheless, a jury awarded her \$1,000.00 against the surgeon because he breached his duty of not disclosing to her the information necessary for an enlightened and complete defense.

A kindred duty of the physician is to give the patient adequate instructions or precautions to prevent aggravation of a condition. In Iowa a case is reported in which the patient and two witnesses testified that the physician directed the patient to use his leg after the cast was removed and to walk with crutches, but that no directions as to the manner or extent of such use were given and that following the use which was made, the bone did not unite well. In awarding damages to the patient the jury found that correct instructions as to the proper care and use of his leg had not been given, that he had wrong directions as to the use of his leg, and that the diseased condition which existed at the time of the trial was caused or aggravated by the use of the leg. The jury made the further finding that with proper advice the full use of his leg would have been restored, or at least the disease of the bone would have been ameliorated.

The great value of written instructions was demonstrated in a case tried in the Federal Court here in Atlanta in which the patient denied that he had any instructions from the surgeon with reference to returning to him for further examination and observation. The patient had been written several letters and a member of his family had been written at least once. These letters were produced at the trial following notice and disproved beyond a peradventure the denial of notice made under oath by the patient.

In conclusion, I repeat, (1) the patient should be advised clearly of the nature and extent of his trouble, the risk involved, and the possibility of other conditions being found which may require operative procedure, and (2) the doctor should be careful to preserve the evidence of the fact that his patient has been clearly and completely advised.

John A. Dunaway, LL.B., Atlanta, Ga.

physician's bookshelf



Books Received

Friedberg Charles K., M.D., *Diseases of the Heart*, W. B. Saunders Company, Philadelphia, 1956, 1161 pp., 157 figs., \$18.00.

Organized Home Medical Care in New York City, A Study of Nineteen Programs, by the Hospital Council of Greater New York, The Commonwealth Fund, Harvard University Press, Cambridge, Mass., 1956, 539 pp., \$8.00.

Haagensen, C. D., M.D., *Diseases of the Breast*, W. B. Saunders Company, 1956, 751 pp., 44 figs., 25 charts, \$16.00.

Harry, Ralph G., F.R.I.C., *Cosmetics, Their Principles and Practices*, Chemical Publishing Company, Inc., New York, 1956, 786 pp., \$17.00.

Goldman, Mervin J., M.D., *Principles of Clinical Electrocardiography*, Lange Medical Publications, Los Altos, Calif., 1956, 310 pp., \$4.50.

Kelley, Stanley, Jr., *Professional Public Relations and Political Power*, The Johns Hopkins Press, Baltimore, 1956, 247 pp., \$4.50.

Sections of Neurology and Section of Physiology, Mayo Clinic, *Clinical Examinations in Neurology*, W. B. Saunders Company, Philadelphia, 1956, 370 pp., 76 figs., \$7.50.

Stokes, Dillard, *Social Security — Fact and Fancy*, Henry Regnery Company, Chicago, 1956, 208 pp., \$4.00.

Reviews

Ivy, A. C., Ph.D., M.D.; Pick, John F., M.D.; and Phillips, W. F. P., M.D., *OBSERVATIONS ON KREBIOZEN IN THE MANAGEMENT OF CANCER*, Henry Regnery Company, Chicago, 1956, 84 pp., 8 tables, 5 illustrations, \$2.50.

The controversy concerning the drug, Krebiozen, rages on; and the titled volume above explains partially, at least, why there is so much controversy.

The theory put forth by Doctors Ivy, Pick, and Phillips in this small monograph relative to the action of their substance which they have named without actually knowing its origin, composition, or chemical structure is not too lacking in logic, and in reality, the theory is probably every bit as fitting as any other theory we have today. That state of ignorance is no less deplorable. It must be noted, moreover, that even this chapter on "Theory" is replete with generalization of assumptions derived from little or poor evidence. Lack of knowledge of the origin, etc., of Krebiozen is not to be criticized in itself, for anyone treating patients with cancer would be only too happy to use any drug from which benefit is derived whether or not these purely academic problems have been solved.

Probably the most criticism of the work reported in this volume should be leveled at the scientific method utilized, most examples of which are too numerous to mention in this review. This reviewer was quite surprised to find that despite all the adverse acceptance of Krebiozen by investigators other than Ivy, the latter should have and did not conform strictly to accepted methods of study. In any study based primarily on subjective response—as most of the Krebiozen groups were—it is absolutely essential that the study be made

by the "double-blind control" method. The authors admit that this was not done "only because of the lack of funds and facilities" (page 13). One experienced with the method at once realizes the inadequacy of this explanation. It should have been apparent to Dr. Ivy and his coworkers that full case histories of every patient receiving the drug would have to be published for critical review before any scientific acceptance of the work would be possible. The authors present in all only 30 case histories (abridged) out of 687 patients treated. Even among these 30 cases there is all too often lack of histologic proof of malignancy, an admixture of agents used in therapy, and the ever-present lack of controlled study. These faults make the cases reported, and indeed the entire statistical analysis, almost worthless.

The book contains so many scientific "half-truths," it strongly suggests it was produced for lay consumption rather than medical study. An excellent example of this is found in the chapter on preparation, etc., of the material (Chapter II):

"An extract of *Actinomyces bovis* (Hartz) was used to stimulate the RES. This organism was used because it is present in a granulomatous tumor in cattle (lumpy jaw). This tumor is morphologically rich in cells of the RS . . ."

I dare say every physician in the United States knows full well that "Lumpy Jaw" is Actinomycosis in cattle; certainly he knows the disease is not a tumor. It is a tumefaction, but not a neoplasm, not a tumor. Likewise, (page 8) do the authors consider medical personnel too naive, or too ignorant, to be told what the organic solvent is which is used in the separation process to prepare the substance? Or what kind of malignant tumors (page 9) were present in the dogs and cats used to assay the drug?

In general, this reviewer agrees with the authors that the substance Krebiozen does deserve further study and possible use; but to be of value the study must be carried out under more acceptable conditions than the reported was, and it would probably be of more benefit if done by a group of workers with more objectivity.

The volume is not recommended for inclusion in any medical library except as a splendid example of how not to report medical cases or carry out a statistical study.

Neil G. Perkinson, M.D.

Cutolo, Salvatore, R., M.D., with Arthur and Barbara Gelb; *BELLEVUE IS MY HOME*, Doubleday & Company, Inc., New York, 1956, 317 pp., \$4.00.

Aside from its existing title, this very interesting and thorough book may aptly have been subtitled, "In Defense of City Hospitals." With the many criticisms so prevalent today revolving around many of our urban hospitals, it is refreshing to have an individual such as Dr. Cutolo, who has been connected with Bellevue for over 25 years, tell his institution's story with great respect and admiration. He supports with warmth and love its many assets and defends its unavoidable imperfections.

The story of Bellevue is a vast one—comparable with any city hospital except for size. With 15 buildings occupying over five city blocks, Bellevue could be en-

visioned as a miniature city, not only from its population and budget statistics, but from the fact that this hospital is in many ways as self-contained as a municipality.

Although the workings of this institution are as many and varied as they are complex, Dr. Cutolo has done a wonderful job in outlining the details involved in the coordination of Bellevue's activities so that one gains rare insight into the workings of this hospital. Woven into this synopsis are interesting histories of casualties resulting from such catastrophes as the Empire State Building plane crash and the burning of the "Normandie." Bellevue's rehabilitation, alcoholic, and psychiatric centers are discussed at length, as well as the growth and history of Bellevue Hospital, and the "firsts" in medical pioneering that can be credited to this institution.

To both the physician and the layman, this book is highly recommended as a factual study of one of our nation's best known hospitals.

Isadore Mehan, M.A., M.D., ROENTGEN SIGNS IN CLINICAL DIAGNOSIS, W. B. Saunders Company, Philadelphia, 1956, 1058 pp., 780 figs., \$20.00.

This book is written primarily for medical students, residents in radiology and in allied specialties, and practicing physicians. The book is of a general nature, covering many subjects fundamental to radiology. There are chapters on radiographic technique, protection from roentgen irradiation, radiological anatomy and physiology, and the diagnosis of the systems of the body radiographically. The book is a large one, being 1058 pages in length, and having 2216 illustrations. There are many sketches and photographs throughout the book, illustrating the radiographic appearance of lesions.

The writer has approached his subject on the basis of objective signs as seen in roentgenograms. As stated in the preface, the text is organized to promote some idea of the limitations as well as accuracy in diagnosis by pointing to the technical and anatomical facets behind roentgen signs. All in all, this book would seem to be a good one for basic radiology.

Ted F. Leigh, M.D.

Gross, Harry, M.D., and Abraham Jezer, M.D.: Treatment of Heart Disease, A Clinical Physiologic Approach, W. B. Saunders Company, Philadelphia, 1956, 549 pp., \$13.00.

Treatment of Heart Disease by Harry Gross and Abraham Jezer, physicians at the Montefiore Hospital and Columbia University, New York, represents "A Clinical Physiologic Approach" to the problems of heart disease. As the authors state, "This is not a book on cardiac physiology, nor is it a compilation of signs, symptoms and therapy of heart disease. It is, rather, a presentation of therapy in heart disease based upon sound physiologic principles." The first division of the book is very helpful and adequately fulfills its heading, "The basic mechanisms of cardiac symptoms and their management." Included in this portion are directions for and discussion of the use of digitalis, quinidine, and other cardiac drugs, also various diets useful in therapy and the indications for their use.

Part II deals with hypertensive heart disease and arterio-sclerotic heart disease and includes briefly the surgical treatment of aneurysms, infarcts, and occlusive disease.

Part III—Diseases of the heart secondary to inflam-

mation, includes rheumatic fever, subacute bacterial endocarditis, syphilis, cor pulmonale, non-specific myocarditis, and pericarditis. The section devoted to rheumatic fever and rheumatic heart disease is inadequate for a thorough discussion of these problems, but gives good general information and is timely.

Part IV—Congenital Heart Disease—No attempt is made to cover all the defects but a very good general discussion is given, including good diagrams of the common defects borrowed from Rushmer, R. F.: *Cardiac Diagnosis: A Physiologic Approach*—Saunders. I heartily approve the attitude that wherever possible these children should be treated as normal individuals as regards their activity, social contacts and education.

Part V—Surgery and pregnancy in the cardiac patient are briefly discussed, making a plea for close cooperation between the surgeon, anesthesiologist, and cardiologist. Too little space is devoted to the causes and management of cardiac arrest.

The best part of the book is the last division, dealing with the cardiac patient as a person, with all his emotions, adjustments and rehabilitation. The chapter "Living With a Sick Heart" is excellent and should be read by every physician. "Reasonable care and intelligent cooperation can increase the usefulness, the comfort, the life and the happiness of most of these people."

The appendix contains full listing of diets, menus, and many useful recipes simply stated for these restricted diets.

In summary this book is thoroughly readable, up-to-date, and represents a welcomed different approach to the treatment of heart disease. It fulfills the purpose of the authors "to reach the general physicians, who, imbued with the physiological point of view may more readily understand the symptoms and clinical course of his patients."

Thomas L. Ross, Jr., M.D.

Frederick, Portia M., and Carol Towner, The Office Assistant in Medical or Dental Practice, W. B. Saunders Company, Philadelphia, 1956, 55 figs., 351 pp., \$4.75.

No matter how long a physician or dentist runs his office he will always find some new method, some small trick, or a little different procedure to help improve the smooth running and efficiency of his office. This book is a compilation of the ways and means, whys and wherefores of how to run a medical or dental office.

This book is written primarily for an office assistant. Nevertheless, every physician or dentist will find something of value within its pages. Anyone working in an office, especially those who are new in the field, will find it of invaluable assistance as a guide to all phases of office procedure. Problems of medical ethics and medical legal affairs are briefly but well discussed. Various techniques of office procedure are explained—including billing and bookkeeping; care of instruments; how to assist with physical examinations; and how to prepare and administer medications. The discussions are clear and concise.

All will profit by a study of this manual—from the office assistant beginning this type of work to very capable experienced personnel who have worked in the field for years. A physician or dentist could easily use this as a basis for office procedure each time a replacement must be made in his personnel. It is highly recommended.

Christopher J. McLoughlin, M.D.

THE ASSOCIATION

Executive Committee

October 28, 1956, Atlanta

CHAIRMAN CHAMBERS called the Executive Committee of Council to order at 2:15 p.m.

Members present: W. Bruce Schaefer, Toccoa, President-Elect; David Henry Poer, Atlanta, Secretary; George R. Dillinger, Thomasville, Finance Committee Chairman, and J. W. Chambers, LaGrange, Council Chairman.

Chairman Chambers read a motion previously passed by Council requesting that the Executive Committee select a review board in connection with "Dependents' Medical Care Act (Public Law 569)." By general agreement, it was recommended and approved that a five-man review board with a three-month rotating chairmanship be set up and that Charles S. Jones, Atlanta, be appointed chairman of the board, with T. Sterling Claiborne, Atlanta, a member; George Holloway, Atlanta, a member; M. F. Simmons, Decatur, a member; J. Frank Walker, Atlanta, a member, and a consulting physician yet to be designated by the Georgia Medical Association. It was further recommended and approved that Mr. Francis Shackelford, attorney of the firm Alston, Sibley, Miller, Spann and Shackelford, be employed as legal counsel for the Dependents' Medical Care Program.

Chairman Chambers called for the date of the next meeting of the Executive Committee of Council; the meeting was set for November 17 at 7 p.m., in Atlanta.

There being no further business, the meeting was adjourned.

Council of the MAG

October 28, 1956, Atlanta

THE SPECIAL CALLED MEETING of the Council of the Medical Association of Georgia was called to order at 10:15 a.m., October 28, 1956, at the Academy of Medicine, Atlanta, J. W. Chambers, LaGrange, Chairman.

Association officers present were: W. Bruce Schaefer, Toccoa, President-Elect; David Henry Poer, Atlanta, Secretary; Carl C. Aven, Marietta, 1st Vice-president; Bernard P. Wolff, Atlanta, 2nd Vice-president; and Thomas W. Goodwin, Augusta, Speaker of the House of Delegates. Councilors present included: George R. Dillinger, Thomasville, 2nd District; W. G. Elliott, Cuthbert, 3rd District; J. W. Chambers, LaGrange, 4th District; J. G. McDaniel, Atlanta, 5th District; Henry H. Tift, Macon, 6th District; D. Lloyd Wood, Dalton, 7th District; F. G. Eldridge, Valdosta, 8th District; Charles R. Andrews, Canton, 9th District; and Vice-councilor J. Victor Roule, Augusta, acting as councilor for the 10th District in the absence of H. L. Cheves, Union Point. Vice-councilors present included: J. Z. McDaniel, Albany; Luther H. Wolff, Columbus; Charles S. Jones, Atlanta; Ralph Fowler, Marietta. AMA Delegates present were Spencer Kirkland, Atlanta, and Eustace A. Allen, Atlanta. Also present were Chris McLoughlin, Atlanta, MAG Public Relations Committee Chairman; Edgar Woody, Jr., MAG Journal Editor, and R. A. Billings, Atlanta, Georgia Medical Association. As requested Mr. Francis Shackelford and Mr. William

Spann, attorneys of the firm of Alston, Miller, Sibley, Spann and Shackelford, representing the Association in regard to the status and practice of medicine in Georgia were present. Mr. Earl H. Bowman, Atlanta, Special Advisor on Public Law 569, Messrs. Krueger and Kiser and Miss Frances Porcher of the Headquarters Office were also in attendance.

The chairman called on Mr. Krueger for a review of the minutes of the September 15-16, 1956, Council meeting and the September 16, 1956, Executive Committee of Council meeting.

MAG - RICHMOND COUNTY MEDICAL SOCIETY PROBLEM—A proposed draft of a letter on ethics from the Medical Association of Georgia to be used in advising Richmond County Medical Society was read and discussed along with a legal opinion submitted by Mr. Shackelford.

It was moved that the Council of the Medical Association of Georgia approve and transmit the aforementioned letter of advice and the legal opinion submitted by Mr. Shackelford to the proper authorities of the Richmond County Medical Society. The motion also requested that copies of the two documents be sent to the Association's Medical Education Committee, the Association's Physician-Institution Relations Committee, and to the president and secretary of each component county medical society of the Medical Association of Georgia with a covering letter informing them that the original letter was approved by Council and transmitted to the proper authorities of the Richmond County Medical Society along with the legal opinion of Mr. Shackelford and sent to these county societies as information only. Discussion ensued with Drs. Goodwin, Luther Wolff, Henry Tift, and Eustace Allen raising certain questions in connection with these documents and their contents. It was clearly brought out by the attorneys that the Council should distinguish between applications for membership and disciplinary measures concerning physicians already belong to the Association. Mr. Shackelford further stated that the first problem of the component county societies dealt with the matter of admission to the societies. The motion carried and was approved, and the executive secretary was instructed to transmit these two letters as indicated in the motion.

The proposed draft subsequently approved by the Council of the Medical Association of Georgia in advising the Richmond County Medical Society on the problem of medical ethics and the legal opinion furnished by Mr. Francis Shackelford are as follows:

"President and Secretary

"Richmond County Medical Society

"Assuming for present purposes that the serving of pay patients by physicians employed by a corporation is made *legal* by Georgia Code Annotated 32-149 with respect to the Eugene Talmadge Memorial Hospital, you have asked whether it follows that such practice falls within the Principles of Medical Ethics adopted by the Medical Association of Georgia. While we shall answer your question on the assumption stated, we should nevertheless point out that the Association's attorneys have advised us that in their opinion the Talmadge Hospital may not lawfully charge pay patients for medical services. A copy of the opinion covering this and other points is enclosed for your information.

"The legality of the corporate practice and the ethics

of such practice are normally treated together to condemn the corporate practice of medicine. However, a legal standard may call for less than an ethical standard. Statutory law sometimes adapts itself to particular ends; the ethics of the Medical Association of Georgia, which are the same as those of the American Medical Association, deal in broad principles, admitting of no exception based on mere convenience or legal sanction.

"These broad principles are reflected in Chapter I, (1) of the *Principles of Medical Ethics of the American Medical Association*:

The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration.

"Chapter VII, (4) says:

Free choice of physician is defined as that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patients and physicians.

"That such free choice cannot exist in a corporate practice where the doctor is chosen and compensated by the corporation and the patient has no direct control over the doctor is shown by Chapter VII, (5):

A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people.

"*The report of the Council on Medical Service* as adopted by the House of Delegates of the American Medical Association, June, 1956, says at page 8:

We recommend that it be the policy of the American Medical Association that funds received from the private practice of medicine by salaried members of the clinical faculty of the medical school or hospital should not accrue to the general budget of the institution and that the initial disposition of fees for medical service from paying patients should be under the direct control of the doctor or doctors rendering the service.

"At page 9, the House of Delegates added to the *Report*:

Nothing in this Report is meant to condone the corporate practice of medicine or policies which result in the diversion of physicians' fees to a corporation or governmental agency."

"It seems abundantly clear from these quotations that a hospital which accepts pay patients, receives fees for medical services, and hires the performing physician on a salary or fee percentage basis is acting outside the ethics recognized by the American Medical Association. *The Constitution and By-Laws of the Medical Association of Georgia*, as revised by the House of Delegates May 15, 1956, Chapter XII, 1, adopts the *Principles of Medical Ethics of the American Medical Association* as the principles of the Medical Association of Georgia.

"In addition, those County Societies in Georgia which have adopted the *Model Constitution and By-Laws for County Societies* have adopted the language of Chapter VIII which says:

The Principles of Medical Ethics of the Ameri-

can Medical Association shall govern this Society."

"Whether or not Ga. Code Ann. 32-149 allows the Eugene Talmadge Memorial Hospital to accept pay patients, bill them directly for medical services, and compensate the performing physicians by salary or by giving them a percentage of the fees collected, the ethical principles of the Medical Association of Georgia clearly condemn the corporate practice of medicine. It is therefore immaterial that in a particular case corporate practice may be authorized by statute. If a doctor is an employee of a corporation that is practicing medicine or if pursuant to a contractual arrangement he is dividing his fees with a corporation, he may not be admitted to membership in the Medical Association of Georgia because to do so would be tantamount to condoning a breach of its own ethics by a doctor, who through his conduct, is enabling a corporation to practice his profession.

"If the Medical Association of Georgia wishes to maintain the trust the medical profession has enjoyed historically it must not admit to membership a doctor who, innocently or otherwise, is helping a corporation violate the Association's Principles of Ethics. Its stand against the corporate practice of medicine in any form is soundly based upon the protection of both the public and itself in an area so sensitive that physical welfare and even life are always at stake. The corporate form developed and met with success because it put a shield of maximum financial liability between a businessman and the fate of his business venture. The corporate protection has worked well in the business context but has been uniformly rejected in the professions. One who furnishes professional services can have no limit put on his financial liability or on his professional honor. The professional man does not advertise; he may not hide behind the anonymity of the corporate fiction; he must risk his professional reputation on every decision he makes. For these reasons the Principles of Ethics of the Association do not tolerate corporate practice.

"It is believed clear from the preceding summary of Principles of Ethics and the reasons for these Principles that the Medical Association of Georgia must not admit to its membership any doctor who condones or makes possible the corporate practice of medicine whether or not such practice should have been declared by court or legislature to be legal.

"Respectfully,

"David Henry Poer, M.D.

"Secretary."

"September 27, 1956.

"Medical Association of Georgia

"875 West Peachtree Street, N. E.

"Atlanta 9, Georgia.

"Gentlemen:

"You have asked us to furnish you our opinion on (1) whether or not a corporation may practice medicine in Georgia, (2) whether a different rule applies to a nonprofit corporation practicing medicine, (3) whether the contractual return, directly or indirectly, to a corporation by a doctor-employee of all or any part of a fee from a pay patient constitutes the corporate practice of medicine, (4) whether the return, directly or indirectly, of all or any part of a fee to a corporation by a radiologist, pathologist or anesthesiologist employed

by such corporation constitutes the corporate practice of medicine, and (5) whether or not the Eugene Talmadge Memorial Hospital is practicing medicine by collecting medical fees from pay patients even assuming it is authorized to do so by statute.

"Question 1

"Under the laws and decisions of Georgia, along with the laws and decisions of the overwhelming majority of other states, a corporation may not practice medicine. Pursuant to Ga. Code Ann., Section 84-90, only an individual may obtain a license to practice medicine and, in order to do so, he must furnish evidence of good moral character, as well as proof that he is a graduate of a college of medicine in good standing with the State Board of Medical Examiners. The public policy reflected in the Georgia licensing statutes has a history as old as the professional status of the physician and surgeon. Rooted in the common law itself, it is based on the principles that no professional man may hide behind the anonymity of an artificial creation such as a corporation should he fail to fulfill the exacting personal and professional standards required. While there is no Georgia decision in which a suit has been brought against a corporation in this State to restrain it from practicing medicine, there are analogous decisions in the fields of law and dentistry that lead to the conclusion that it is unlawful for a corporation to practice medicine in this State.

"In *Atlanta Southern Dental College v. The State*, 51 Ga. App. 379, 180 S.E. 620 (1935), and *Rivers v. Atlanta Southern Dental College*, 187, Ga. 720, 1 S.E. 2d 750 (1939), the Georgia Courts declared that the extraction of a tooth for a few cents more than the actual cost of material or the taking of an impression and fitting of dental plates constitutes the practice of dentistry and that the defendant corporation could not practice dentistry. Likewise in *Boykin v. Hopkins*, 174 Ga. 511, 162 S.E. 796 (1932), it was decided that a charter could not be granted to a corporation authorizing it to practice law in this State in any of its branches, whether the practice be confined to the courts or outside the courts or a combination of both. One of the fundamental reasons why a corporation is not permitted to practice a learned profession was stated as follows In *re Opinion of the Justices*, 289 Mass. 606, 194, N.E. 313 (1935), striking down an attempt of a Massachusetts nonprofit corporation to practice law:

... it demands on the part of the attorney undivided allegiance, a conspicuous degree of faithfulness and disinterestedness, absolute integrity, and utter renunciation of every personal advantage conflicting in any way directly or indirectly with the interests of his client. Only a human being can conform to these exacting requirements. Artificial creations such as corporations or associations cannot meet these prerequisites.

"For exactly the same reason a corporation is not allowed to practice medicine in this state.

Question 2

"Having given you our opinion that a corporation may not lawfully practice medicine in Georgia, we now turn to the question of whether the practice of medicine by a nonprofit corporation is an exception to the general rule barring the corporate practice of medicine by a profit corporation. While there are no Georgia decisions on this point concerning any of the learned pro-

fessions, the reason for the general rule applies with equal persuasion to a nonprofit corporation, and in this opinion we are supported by decisions of three other states and the opinions of Attorneys General of six additional states. Illinois: *People ex rel. Chicago Bar Ass'n v. Motorists Ass'n of Illinois*, 354, Ill. 595, 18 N.E. 827 (1939); *People v. Association of Real Estate Taxpayers of Illinois*, 354 Ill. 102, 187 N.E. 823 (1933). Iowa: *Iowa Hospital Association v. Iowa State Board of Medical Examiners*, No. 63095 Equity, District Court of Polk County, Iowa, November 28, 1955. Massachusetts: In *re Opinion of the Justices*, 289 Mass. 606, 194 N.E. 313 (1935). California: Op. Atty.-Gen. No. 48-32, May 19, 194; Colorado: Op. Atty.-Gen., May 19, 1954; Florida: Op. Atty.-Gen., March 25, 1955; Idaho: Op. Atty.-Gen., May 26, 1954; Ohio: Op. Atty.-Gen., 1751, August 20, 1952; West Virginia: Op. Atty.-Gen., June 10, 1955.

"It would be too dangerous to the public interest to permit an artificial creation—a corporation—to practice medicine, regardless of the fact that it is non-profit in nature. Only the moral character, reputation, responsibility and pride of a human being can suffice to protect the patient in matters so vital that they always involve his physical welfare and often even his life. A corporation because of its very anonymity would lack this all-important individual responsibility regardless of the fact that such a corporation might be nonprofit. The Attorney General of Colorado has pointed out that nonprofit corporations have their own budget problems, and that lay administrators of such corporations may well emphasize a balanced budget so much that the corporation becomes casual if not callous toward its patients. The Attorney General said on this point:

It may also be said that the principle of control over professional activity by unlicensed personnel exists in the situation of employment of doctors by a nonprofit corporation as well as by a for-profit corporation. It may be true that the profit motive is absent in the nonprofit corporation, but the profit motive is only an element which goes to the likelihood of the exercise of such control, rather than to the power to exercise such control. And we should notice the fact that the consideration of cutting costs to stay within a budget may be conducive to the exercise of such control in much the same way as is the profit motive.

Question 3

"Since we have now concluded that neither a profit nor nonprofit corporation may lawfully practice medicine in this State, the next question is whether the contractual return, directly or indirectly, to a corporation of all or any part of a fee by a doctor-employee of such corporation constitutes the practice of medicine by the corporation itself. It very clearly would do so in our judgment, because the employee-doctor would in reality be an agent of the corporation to which he is contractually required to return all or a part of the fee received by him from a pay patient. This would be as clearly the practice of medicine by the corporation as if the patient had come to the corporation itself and asked to be treated without requesting any particular doctor. It is immaterial also if the doctor-employee fails to disclose his agency, for the evil lies in the fact that the corporation by contract—oral or written, exact in its terms or based upon a practical understanding—is

acquiring all or a part of a fee from a pay patient. The Florida Attorney General ruled on this point in his opinion of March 25, 1955, saying:

... we are bound to conclude that a corporation, whether or not organized or operated for profit, may not practice medicine and surgery in this state directly because of its inability as a legal entity to obtain a license, nor can it practice indirectly by hiring licensed members of that profession to do the actual professional work involved. It is immaterial whether the compensation to the licensed person so hired be on a straight salary basis or in the form of a contractual percentage arrangement. . . .

Question 4

"As to whether radiology, pathology, or anesthesiology constitutes the practice of medicine, we believe that these specialists clearly fall within the language of Ga. Code Ann. Section 84-906, defining the practice of medicine to include the "diagnosis or treatment of disease or injuries of human beings." While no Georgia cases have been decided on this point, it was held in *Iowa Hospital Association v. Iowa State Board of Medical Examiners*, No. 63095 Equity, District Court of Polk County, Iowa, November 28, 1955, that radiology and pathology, involving diagnosis or treatment or both, constitute the practice of medicine. Likewise the Attorney General of Idaho on May 26, 1954 ruled specifically that radiologists, pathologists, and anesthesiologists practice medicine, and on June 10, 1955, the Attorney General of West Virginia made the same ruling.

Question 5

"Your final question concerns whether or not the Eugene Talmadge Memorial Hospital is permitted by statute to practice medicine pursuant to special legislation authorizing it to accept "pay patients." Ga. Code Ann., Section 32-149. Assuming the answer is in the affirmative, the question then is whether it is practicing medicine as a corporation even though lawfully authorized to do so. The Talmadge Hospital is in a separate class from that of all other incorporated hospitals in the State by virtue of the law affecting it alone.

"The Board of Regents in its final plans for operating the Talmadge Hospital has construed the special 'pay patients' statute to mean that the hospital may in effect charge fees for medical services. So far there has been no Georgia case determining whether or not the Board's plan of operation in this respect exceeds the statutory authority of the hospital to accept pay patients. In our opinion, it does, because the special Talmadge Hospital statute must be taken in conjunction with Ga. Code Ann., Section 84-907, which limits the practice of medicine by any corporation. Quite consistent with this statute the Talmadge Hospital could accept pay patients insofar as hospitalization services are concerned. This would eliminate any possible conflict with the general statute limiting the practice of medicine to individuals, and the courts of this State as a cardinal principle of construction construe a statute, particularly an Act of special legislation, so as to avoid any conflict with prior general legislation. See *Rivers v. Atlanta Southern Dental College*, 187 Ga. 720, 1 S. E. 2d 750 (1939); *Mills v. Scott*, 99 U.S. 25 (1878); *Erwin v. Moore*, 15 Ga. 361 (1854); *Daniel v. Citizens & Southern Natl. Bank*, 182, Ga. 384, 185 S.E. 696 (1936).

"Even if it is assumed that the Talmadge Hospital is

authorized by special legislation to practice medicine it, of course, would follow that any such practice by it would constitute the corporate practice of medicine quite regardless of the fact that it was authorized by law to do so.

"If there are other questions you may have, please let us know."

Sincerely yours,

For Alston, Sibley, Miller, Spann &
Shackelford

FS:h

F. Shackelford.

"MEDICARE," PUBLIC LAW 569—The Chairman then called on Charles S. Jones, Chairman of the Council Committee on Public Law 569 Fee Schedule. Dr. Jones recommended that the Association's representatives who will negotiate in Washington, D. C., November 12, 1956, with the Department of the Army should take his committee's prepared fee schedule of 190 procedures and further correlate the figures on these procedures, and that the Council should delegate authority to these representatives to negotiate with the Department of the Army in Washington on the basis of said procedures and material gathered from the Council Committee on Fee Schedule, the recommendations of the specialty societies of Georgia, including the General Practitioners, and the Columbus Blue Shield Plan. It was moved that the Council accept Dr. Jones' recommendation, and this motion carried.

The Chairman called on Mr. Earl H. Bowman, special advisor on matters dealing with the fiscal administration of Public Law 569, to further explain to Council and advise Council on the means and methods of administration entailed therein. After Mr. Bowman's report, discussion was lead by Dr.'s Tift, Wolff, Jones, Mr. Bowman and Mr. Krueger on this matter. It was moved that the Medical Association of Georgia act both as its contracting agent and fiscal administrator in handling Public Law 569 and that the three Blue Shield operations in Georgia act in an advisory capacity at the discretion of both the Association and the Blue Shield plans.

Chairman Chambers then brought up discussion on the matter of a review board as requested in the Department of the Army contract. The function and operation of this Board was clarified and it was moved that the members of the Executive Committee of Council present select a review board and report to the Council at a later time during this day. This motion was approved.

The Chairman then opened for discussion the Association's representatives to negotiate with the Department of the Army in Washington in behalf of the doctors of Georgia, on Public Law 569. It was moved that the Chairman of the Fee Schedule Committee of Council, Dr. Jones; the Chairman of the Finance Committee, Dr. Dillinger; the Chairman of Council, Dr. Chambers or his designated representative; the Executive Secretary, Mr. Krueger; Legal Counsel, and others if necessary, represent the Association. The motion was carried.

It was moved that the Association request American Medical Association legal aid prior to and during negotiation with the Department of the Army.

After discussion led by Dr.'s McDaniel and Eldridge,

it was recommended and approved that no voting member of the Council should serve on the Review Board since the Council will be responsible for the operation of the Dependent Medical Care Program (Public Law 569) in Georgia.

Dr. Chambers raised the question as to how Council wished the administration of this program handled; by unanimous agreement it was recommended that it should be handled by the Executive Committee of Council. Dr. Tift raised the question of remuneration of the MAG Executive Committee of Council functioning as Fiscal Agent. After further discussion by Dr.'s Chambers and Dillinger, it was agreed that the carrying out of the program would not require compensable time in addition to the Executive Committee's regular duties.

Chairman Chambers then presented the Executive Committee's recommendations for the Review Board in connection with this program as follows: The Executive Committee recommended a five-man board with a three-month rotating chairmanship and named to the Board Charles S. Jones, Atlanta, Chairman; T. Sterling Claiborne, Atlanta, George Holloway, Atlanta; M. Freeman Simmons, Decatur; J. Frank Walker, Atlanta; and a consulting physician yet to be designated by the Georgia Medical Association. The Executive Committee further recommended that Mr. Francis Shackelford be employed as legal counsel for this program.

It was moved that the report of the Executive Committee be adopted, and this motion was approved.

MAG EMPLOYEES UNEMPLOYMENT COMPENSATION—Mr. Krueger presented a letter from the MAG Attorney, Mr. John Dunaway, concerning unemployment compensation for the full-time employees of the Medical Association of Georgia. In the letter Mr. Dunaway asked the Association whether or not he should request a hearing from the Georgia Department of Labor concerning whether or not the Medical Association of Georgia is subject to the payment of the statutory assessments toward the unemployment compensation fund.

It was moved that the Association instruct Mr. Dunaway to request a hearing on this matter; the motion was approved.

MAG FINANCE COMMITTEE REPORT—Dr. Dillinger, Chairman of the MAG Finance Committee, presented the following items for approval of Council as additions to the 1956 budget: 1956 Annual Session—\$2,825.03; Annual Audit—\$100.00; Stationery and Printing—\$250.00; Postage—\$350.00; Telegraph and Telephone—\$600.00; Medical Defense—\$1,500.00; Insurance and Economics Committee—\$200.00; and, Travel—\$500.00. It was moved that funds be approved to cover the above excesses on individual items in the 1956 budget. The motion was approved.

AMA CODE OF ETHICS REVISION—Eustace A. Allen and Mr. Krueger presented information concerning the proposed revision by the House of Delegates of the AMA Code of Ethics. After discussion it was moved that the Medical Association of Georgia's AMA Delegates be instructed to introduce a resolution at the next meeting of the AMA House of Delegates to state "that nothing in the proposed revision be taken as to condone the corporate practice of medicine," and if this were not included in the revision that the present proposed revised Code of Ethics be opposed by our delegates. This motion was approved.

MAG DECEMBER COUNCIL MEETING—Dr.'s Roule and Goodwin invited the Council of the Medical Association of Georgia to hold the December MAG Council meeting in Augusta. They suggested that members of the MAG Medical Education Committee, the President, Secretary, and Governing Board of the Richmond County Medical Society; the President and Dean of the Medical College of Georgia; and the Administrator of the Talmadge Memorial Hospital be invited to attend this meeting. It was approved that the guests listed above would be invited to attend this meeting. Also, by general agreement, Council requested that Mr. Francis Shackelford attend this meeting in connection with the practice and status of medicine.

The Chairman then called for unfinished business and there being none, he called for new business, and there being none the meeting adjourned at 2:40 p.m.

Committee on Legislation

October 10, 1956, Atlanta

THE SECOND MEETING of the 1956-57 Committee on Legislation was called to order at 5 p.m., Wednesday, October 10 in the offices of the MAG, by M. F. Simmons, Decatur, Chairman.

Present in addition to Dr. Simmons were: Eustace A. Allen, Atlanta; J. Frank Walker, Atlanta; Albert M. Deal, Statesboro; J. W. Palmer, Ailey; and Mr. John F. Kiser.

First item of business concerned the proposed meeting on National Legislation with Tom Alphin of the AMA Washington Office. It was voted to hold this meeting at 6 p.m., Thursday, November 8 in Room 6 of the Biltmore Hotel. Mr. Kiser was instructed to notify Dr. Alphin and to make all arrangements for the meeting in conjunction with Dr. Allen, Vice-chairman in Charge of National Legislation.

The second item of business concerned the *amendment to the medical practices act*. Mr. Kiser briefly explained the purposes of the amendment, and Dr. Deal and Dr. Simmons discussed the proposed changes and other suggestions that have been made by various individuals.

Dr. Simmons explained that it is not within the committee's jurisdiction to edit the legislation but merely to see that the bill is introduced and is passed.

Dr. Deal discussed the foreign graduate problem and presented a proposal for a change in the law in regard to temporary licensing of foreign graduates.

It was voted that this matter would become a separate bill and that both the Medical Practice Act Amendment and the foreign graduate amendment should be referred to the Liaison Committee to Study Revision of the Medical Practice Act for their approval and referral back to the committee through Council.

The next item of business concerned meetings with legislators in the 10 Congressional Districts.

Following discussion, 10 physicians were selected to represent districts as follows: 1st District—Albert M. Deal; 2nd District—George R. Dillinger; 3rd District—Robert Pendergrass; 4th District—J. W. Chambers; 5th District—J. Frank Walker; 6th District—Thomas Ross; 7th District—William P. Harbin, Jr.; 8th District—Arthur M. Knight, Jr.; 9th District—W. Bruce Schaefer; 10th District—Goodloe Y. Erwin.

The Chairman was instructed to work with Mr. Kiser in notifying these key men of their appointment, and it

was also voted to invite them to attend the November 8 meeting on national legislation.

The proposed amendment to the law permitting the sterilization of individuals in private institutions was discussed, and further changes were taken under advisement. It was recommended that this bill be introduced but not considered a primary objective of the MAG.

It was voted to table, temporarily, the amendment to the marriage law and a proposed bill making it a criminal act to practice naturopathy in Georgia.

In regard to the matter of Workmen's Compensation Laws as concerns the hiring of persons with pre-existing disease, it was voted to ask Duncan Shepard to attend the next meeting of the committee and discuss this proposed bill.

Mr. Kiser was instructed to provide information to be published in the *Journal of the Medical Association of Georgia* as needed.

There being no further business the meeting was adjourned.

Committee on Mental Health

October 14, 1956, Augusta

THE FIRST MEETING of the 1956-57 Committee on Mental Health of the Medical Association of Georgia was held at the Eugene Talmadge Memorial Hospital on Sunday, October 14, 1956.

Members present were: Rives Chalmers, Atlanta, Chairman; J. R. S. Mays, Macon; W. M. Moncrief, Atlanta; P. T. Scoggins, Commerce; T. J. Vansant, Jr., Marietta; Richard E. Felder, Atlanta; Albert J. Kelley, Savannah; Carl A. Whitaker, Atlanta; Guy V. Rice, Atlanta; T. G. Peacock, Milledgeville. Also present were John Caldwell, Augusta, Chairman, Department of Psychiatry, Medical College of Georgia; Mrs. Charles R. Smith, Columbus, Chairman, Mental Health Committee of the Woman's Auxiliary to the Medical Association of Georgia; Charles R. Smith, Columbus; and Mr. John F. Kiser, Assistant Executive Secretary, Medical Association of Georgia.

TOUR OF DEPARTMENT—The meeting began at 10:30 a.m. in the Department of Neurology and Psychiatry at the Eugene Talmadge Memorial Hospital. Dr. Caldwell discussed the plans of the department and conducted a tour of the wards and clinic. He explained that there are 128 beds, 64 in the closed ward section and 64 in the open ward section. He discussed admission policies and stated that the goal of the department was to establish an intensive treatment service. He explained that the department will spend one-third of its time teaching; one-third of its time in treatment, and one-third of its time in research.

Following further discussion of the plans of the Department of Neurology and Psychiatry of the Talmadge Hospital by other members of the staff, a tour of the hospital was conducted on some of the other floors of the hospital.

Following a luncheon served in the hospital cafeteria, the committee meeting convened at 1:15 p.m.

MILLEDGEVILLE STATE HOSPITAL—Dr. Peacock, Superintendent of Milledgeville State Hospital and Consultant to the Committee on Mental Health of the Medical Association of Georgia, presented the report of the superintendent and business manager of Milledge-

ville State Hospital for the year ending June 30, 1956. Also the complete report of the hospital for the year ending June 30, 1955, was distributed to the committee members. Dr. Peacock discussed these reports briefly.

Members of the committee asked Dr. Peacock for suggestions as to how the Committee on Mental Health could bring about a better understanding of the hospital and its activities by the medical profession and the general public in Georgia.

Various methods were discussed by members of the committee, including a discussion of the plan of the Boston City Hospital in which a wide range of consultants are used on the hospital staff to provide liaison between the medical profession and the hospital. Dr. Vansant discussed the production of a movie describing the services provided at Milledgeville. Dr. Kelley discussed a plan in Indiana which utilized the services of "community volunteers."

The chairman urged the committee members to keep this matter in mind in planning for the committee projects. He stressed that this would be a most important project to help the medical profession and other groups to have a better understanding of the Milledgeville State Hospital. The chairman was authorized to appoint two or more committee members to work with Dr. Peacock on this project.

Following introduction of the members of the committee and visitors, Dr. Chalmers reviewed 1955-56 committee activity and the annual report of the committee presented at the MAG Annual Session in May 1956.

The next item of business was the Council appointments to the Milledgeville Hospital Study Commission. After considerable discussion, it was moved and seconded and duly voted that the committee go on record as recommending to the Council of the Medical Association of Georgia that the appointments to the Milledgeville Hospital Study Commission be reconsidered and that Council consider appointing one member representing the Medical College of Georgia.

MENTAL HEALTH COMMITTEES — The next item of business concerned discussion of the recommendation of the 1955-56 committee in regard to the establishment of Mental Health Committees by county and district societies. It was voted to recommend to Council that the individual councilors encourage component county medical societies to organize mental health committees of the local level as a part of their society activities.

PSYCHIATRIC BEDS IN GENERAL HOSPITALS —The next item of business was a discussion of the use of psychiatric beds in general hospitals.

The chairman discussed the problem of the one or two beds in each Hill-Burton Hospital which have been allotted for psychiatric care. He pointed out the problems on a local level in regard to these beds. The chairman pointed out that general practitioners and other physicians practicing in connection with these hospitals are not familiar with the treatment of psychiatric patients, and therefore the one or two beds allotted for psychiatric care are not used. He also stated that, in general, the laws require the patient to be placed in a local jail pending hearing and commitment to Milledgeville rather than in the local hospital.

Following further discussion, the chairman was authorized to appoint a subcommittee to study this problem



Members of the Committee on Mental Health with the Department of Psychology and Neurology of the Medical College of Georgia, Talmadge Memorial Hospital, Augusta, October 14, 1956. 1st row, left to right: John Kemble, T. G. Peacock, E. James McCranie, Guy Rice, Mrs. Charles Smith, W. M. Moncrief, Paul Scoggins, Rives Chalmers, John Caldwell. 2nd row, left to right: Boyd Sisson, Ph.D., Mr. John F. Kiser, John Manter, Albert Kelley, J. R. S. Mays, Carl A. Whitaker, Richard Felder, T. J. Vansant, Jr.

further and report to the next meeting of the committee.

SCREENING CENTERS—Dr. Rice discussed the proposed screening centers to be established in the Eugene Talmadge Memorial Hospital and one general hospital not connected with a teaching institution. He explained the background of this proposal and read a letter written by Dr. Sellers to Governor Griffin on June 5, recommending that money be appropriated for this program. Dr. Rice explained that the program would require approximately \$300,000 per year initially.

He informed the committee that since June 5th, Dr. Sellers has not heard from the Governor on this matter.

Dr. Caldwell discussed several problems in connection with intensive treatment of acutely ill patients.

Following discussion, the chairman was authorized to appoint a subcommittee to study this problem.

BOOKLET—The next item of business concerned the report of the committee on Continuing Information. In the absence of Dr. Knight, Dr. Felder and Dr. Chalmers reported on the preparation and publication of a booklet in regard to commitment laws to be distributed to all physicians in Georgia.

Dr. Felder explained that most of the material was in final form and after further discussion, Dr. Knight and Dr. Felder were authorized to edit the material and after mailing to the members of the committee for their suggestions, to go ahead and prepare the booklet.

Dr. Peacock suggested that this booklet on commitment laws be distributed at the meeting of the Section on Nervous and Mental Diseases during the Annual Session of the Medical Association of Georgia which begins April 28, 1957. Following discussion, Mr. Kiser was authorized to notify the chairman of this section that the committee would like to participate in the program.

MENTAL HEALTH PAGE—The next item of business concerned the preparation of a mental health page in the *Journal of the Medical Association of Georgia*. Dr. Felder reported on a discussion of the matter with

Editor of the *Journal*, Edgar Woody, Jr. Dr. Felder pointed out that this mental health page must be on a regular monthly basis and with the approval of the committee, the chairman appointed Dr. Felder to assign topics to various members of the committee for the preparation of these articles.

WOMAN'S AUXILIARY—The next item of business was the report of the Chairman of the Committee on Mental Health of the Woman's Auxiliary to the Medical Association of Georgia.

Mrs. Charles Smith of Columbus reported that her committee is making an effort to determine what facilities exist in the communities in the State. She pointed out that her committee will attempt to lend advice and support to the existing facilities and will provide a liaison between the Woman's Auxiliary and the Mental Health Association. She stated her committee is planning to distribute literature from the health department and sponsor programs on mental health.

Dr. Peacock suggested that the Woman's Auxiliary solicit gifts and donations for the State Hospital, and it was also recommended that the local chairman of the committees on Mental Health of the various Woman's Auxiliary Societies visit the State Hospital sometime during the year.

"MILESTONES IN MARRIAGE"—The next item of business concerned discussion of the booklet "Milestones in Marriage." Dr. Kelley pointed out three items in connection with the booklet: (1) He suggested that the booklets be mailed to the seniors in high school rather than distributed in person. (2) He pointed out that this mailing should be followed up by a discussion in the local schools by a designated teacher to meet with the students. (3) He pointed out that in Savannah the Mental Health Association would assist in the mailing of the booklets in cooperation with the Board of Health and the Board of Education.

After further discussion, the committee went on record as approving the booklet, "Milestones in Marriage."

Dr. Whitaker discussed the possibility of assisting Dr. Rice in expanding the mailing list of the *Psychiatric*

Bulletin, now being mailed to a selected group of physicians in the State of Georgia. It was recommended that this matter be looked into between now and the time of the next meeting.

STUDENTS AT STATE HOSPITAL—Dr. Peacock discussed the matter of students touring the Milledgeville State Hospital clinics and wards. Most of the members of the committee expressed opposition to any but those students actually engaged in clinical training touring the wards and clinics of the hospital. After further discussion, the chairman was authorized to appoint two members to investigate and formulate a recommendation as to policy for the next meeting of the committee.

AMA MEETING—The next item of business concerned the meeting of State Chairmen of Mental Health Committees in Chicago, sponsored by the AMA, on November 16-17. The committee went on record as recommending that this be a permanent assignment for the chairman of the committee, and Dr. Chalmers expressed his willingness to attend this meeting again this year. He said he would report back the results of this meeting at the next meeting of the committee.

PROFESSIONAL LIAISON—Paul Scoggins brought up the matter of liaison between the general practitioner and the State Hospital and between the general practitioner and the practicing psychiatrist. He expressed the desire for the committee to discuss this matter as to ways and means of improving communication between the local family physician and the hospital and psychiatrist.

It was recommended that this matter be made an item for discussion at the next meeting of the committee.

It was voted to hold the next full meeting of the committee at the end of February with subcommittees to meet in the interim.

There being no further business the meeting was adjourned.

Interprofessional Council

THE FIRST MEETING of the Interprofessional Council of Georgia was held at 6 P. M., Thursday, October 4, 1956 in the Biltmore Hotel, Atlanta, Ga.

Present were, from the Medical Association of Georgia: Chris J. McLoughlin, M.D., Atlanta; M. F. Arnold, M.D., Hawkinsville; and Mr. John F. Kiser, Assistant Executive Secretary; from the Georgia Dental Association: W. A. Carr, D.D.S., Augusta; Herbert Cohen, D.D.S., Macon; and A. J. Webster, D.D.S., Rome; from the Georgia Pharmaceutical Association: George Mudter, Ph.G., Manchester; Tyre Watson, Jr., Ph.G., Decatur; F. Everett Williams, Ph.G., Statesboro; and Mrs. Regina Baird, Executive Secretary.

Following a social hour and dinner sponsored by the Medical Association of Georgia, the meeting was called to order at 7:30 P. M. by Acting Chairman, Chris J. McLoughlin.

The purpose of the meeting and the purpose of the council itself was discussed at length by the members of the council. It was decided in general that the purpose of the council is: (1) To improve the general health of the people. (2) To promote better interprofessional relations between the groups. (3) To act as a fact-finding body to resolve complaints which may arise between the different professions and to report back to the respective parent organizations.

Mr. Mudter, Mrs. Baird, and Mr. Kiser were authorized to draft a proposed statement of policy and purpose to be considered at the next meeting.

Also discussed was the possibility of adding other members to the council, either in a full membership or ex-officio membership capacity. These included the Joint Secretary of Examining Boards, the Chief Drug Inspector, and a representative of the pharmaceutical houses. No decision was reached on this matter.

Following an introduction of individual members and discussion of the policies and principles, Mr. F. Everett Williams, Statesboro, discussed the proposed revision of the Georgia Pharmacy Law. Mr. Williams explained that two bills would be introduced, one to declare pharmacy a profession, and included in this same bill an amendment of one section of the code with reference to compounding, mixing, and dispensing of drugs, with a requirement that such drugs may only be compounded, mixed, or dispensed under the immediate personal supervision of a Georgia registered pharmacist. He further stated the other bill will embody the standard features of the uniform drug and cosmetic law patterned from the Federal Drug and Cosmetic Law, and will also include the provisions of the Durham-Humphrey Law.

Mr. Williams also discussed the problem of pharmacists practicing without a license and without proper supervision. There then followed a general discussion concerning relations between pharmacists and physicians.

Mr. Kiser discussed the proposed amendments to the Medical Practice Act, including an expanded revocation section and the addition of an injunction clause to the act. Mr. Kiser discussed reasons for this amendment and described the problems facing the State Board of Medical Examiners at the present time.

Dr. Carr explained the recently amended Georgia Dental Law, and discussed how the new injunction provision would function. He discussed various individual cases and described the plans for the future in regard to this law.

A general discussion followed relative to the problem of osteopaths prescribing drugs, the problem of educating the public in regard to the various professions, and the responsibilities of the individual members of the professions.

After discussion, it was moved by Mr. Mudter, seconded by Mr. Williams, and duly voted that three members be appointed from each association, and that one appointment shall be for one year, one for two years and one for three years, and that all subsequent appointments shall be for three-year terms. It was recommended that the delegates from each association take this matter up with their governing bodies.

Following discussion, there was the election of officers as follows: Chris J. McLoughlin, Atlanta, *Chairman*; W. A. Carr, D.D.S., Augusta, *Vice-chairman*; and Mr. George Mudter, Manchester, *Secretary*. It was decided that the chairmanship of the council would rotate among the three professions.

It was voted to request each individual association to finance every third meeting. Financing of the meetings was left open for discussion at the next meeting, which was set for 1:00 P. M., December 2, 1956 at the Biltmore Hotel, Atlanta.

There being no further business, the meeting was adjourned.

ANNOUNCEMENTS

Meeting Calendar

American Medical Association—June 3-7, 1957, The Coliseum, New York City.

American College of Physicians—April 8-12, 1957, Boston, Mass.

American College of Surgeons Regional Meeting—February 4-7, 1957, Roosevelt Hotel, New Orleans, La.

Medical Association of Georgia—April 28-May 1, 1957, DeSoto Hotel, Savannah.

Georgia Society of Anesthesiologists—April 21-24, 1957, Savannah.

Georgia Diabetes Association—April 28-May 1, 1957, DeSoto Hotel, Savannah.

Georgia Society of Ophthalmology and Otolaryngology—May 18-23, 1957, aboard S. S. Silverstar from Charleston, S. C.

Georgia Psychiatric Association—February 18, 1957, Atlanta.

Georgia Urological Association—April 28-May 1, 1957, DeSoto Hotel, Savannah.

Georgia Industrial Surgeons Association—April 28-May 1, 1957, DeSoto Hotel, Savannah.

Atlanta Graduate Assembly—February 18-20, 1957, Atlanta.

Aero Medical Association—May 6-8, 1957, Denver, Colorado. The scientific program will include reports on emergency escape from high performance aircraft, new developments in airline passenger comfort and safety, and current research in manned space satellites. The American Board of Preventive Medicine will conduct exams for certification in aviation medicine in Denver from May 3 to 5. For information, write to the Aero Medical Association, Box 26, Marion, Ohio.

Postgraduate Courses on Diseases of the Chest—The American College of Chest Physicians will present courses on the following dates: January 14-18, 1957, Vanderbilt University, Nashville, Tenn.; February 25-March 1, 1957, Mark Hopkins Hotel, San Francisco, Calif.; and April 1-5, 1957, Bellevue-Stratford Hotel, Philadelphia, Pa. Tuition for each course is \$75.00. For information write to the Executive Director, American College of Chest Physicians, 112 East Chestnut St., Chicago, 11, Ill.

American College of Physicians 1957 Annual Session—April 8-12, 1957, Boston. For information write to Dr. Richard P. Stetson, 203 Commonwealth Ave., Boston 16, Mass.

American Congress of Physical Medicine and Rehabilitation—35th annual scientific and clinical session, September 8-13, 1957, Hotel Statler, Los Angeles, Calif. For information, write to the Executive Secretary, Dorothea C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Ave., Chicago 2, Ill.

Annual Prize Lecture, American Congress of Physical Medicine and Rehabilitation—Manuscripts must be submitted by June 1, 1957. Contest open to medical students, interns, residents, graduate students in the pre-clinical sciences, and graduate students in physical medicine and rehabilitation. For information write to the American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Ave., Chicago 2, Ill.

22nd International Congress for Social Medicine—May 11-June 2, 1957, Vienna, Austria. Theme of the meeting is "University and Public Health, the Place and Task of the University". For specific information write to this *Journal* or to Prof. Dr. T. Antoine, Spitalgasse 23, Vienna 9, Austria.

1957 Mississippi Valley Medical Society Essay Contest—Any subject of general medical or surgical interest including medical economics and education may be submitted by physicians who are members of the A.M.A. and are residents and citizens of the U. S. Cash prize—\$100; gold medal and certificate given. Essays must be submitted by May 1, 1957. Further details may be secured from Harold Swanberg, M.D., Secretary MVMS, 209-224 W. C. U. Building, Quincy, Ill.

New York University Post-Graduate Medical School Courses in January 1957—Modern Concepts in the Etiology, Diagnosis and Treatment of Heart Diseases—5-day full-time course Jan. 7-11, 1957, under the direction of Dr. Charles A. Poindexter. *Seminar in Dermatology and Syphilology* (designed for non-der-

matologists)—full-time course lasting from Jan. 14-25, under the direction of Dr. Marion B. Sulzberger. *Pediatrics Refresher Course*—Full-time from Jan. 14-25, under the direction of Dr. Adolph G. DeSanctis.

Two-week Course in Radiological Safety—January 7 to 18, 1957, New York University Post-Graduate Medical School. Course designed for industrial physicians, industrial engineers, etc. There will also be an optional two-week laboratory session from January 21 to February 1. For further information write to the Dean, NYU Post-Graduate Medical School, 550 First Avenue, New York 16, N. Y.

DEATHS

JAMES MOBLEY COMBS, Atlanta, died on October 15, 1956, at the age of 41. He had been ill for only a month before his death.

Dr. Combs was born in Monticello and grew up in Covington. He attended Emory at Oxford and graduated from Emory University. He received his M.D. degree from the Medical College of Georgia in 1942, graduating with honors. During the second World War Dr. Combs served as a lieutenant in the U. S. Navy; he spent most of his time in the service in the Pacific Theatre of Operations. He had practiced in Atlanta for the past 10 years.

Dr. Combs was a member of the Fulton County Medical Society, the First Baptist Church, Cherokee Country Club, West End Businessmen's Association, Beta Kappa Phi, and Alpha Omicron Alpha, medical fraternities.

Funeral services were held on October 17th at Spring Hill, Atlanta, with burial in Social Circle, the home of his parents. Survivors include his wife, the former Miss Constance Beck; two daughters, Diana Beck Combs and Dorothy Gibbs Combs; a son, James Mobley Combs, Jr.; and his mother, Mrs. J. Walker Combs, Sr.

RUPERT H. FIKE, Moultrie, died on October 29, 1956, in Moultrie. He was 68 years of age.

Dr. Fike was a native of South Carolina and a graduate of Clemson College, class of 1908. He received his M.D. degree from the University of Tennessee and did postgraduate work in radiology at Johns Hopkins and the Massachusetts General Hospital, Harvard University Medical

(Deaths)

School, the Mayo Clinic, Curie Institute in Paris, France, and Memorial and Presbyterian Hospitals in New York City. Dr. Fike was roentgenologist and physician-in-charge of Atlanta's Steiner Clinic for 23 years. When the famous cancer hospital was closed by the Hospital Authority in 1945, he became staff radiologist at St. Joseph's Infirmary, Atlanta. In 1949 he joined the staff of the Vereen Memorial Hospital in Moultrie and also served as radiologist for the hospitals at Adel and Camilla until poor health forced him to limit his activity to Moultrie.

Dr. Fike was the first Southerner appointed a director of the American Society for the Control of Cancer, a position he held for nine years. In 1952 he received an honorary degree of doctor of science from Clemson College.

Dr. Fike was a member of the Colquitt County Medical Society, Phi Rho Sigma medical fraternity, a Mason and a member of the First Methodist Church, Moultrie. He was a member of Rotary International for 35 years.

Funeral services were held in Moultrie and in Clemson at the graveside. Surviving Dr. Fike are his wife; a daughter, Miss Eleanor Fike, Moultrie; a son, R. H. Fike, Jr., Atlanta; and two grandchildren.

JAMES NATHANIEL ISLER, Meigs, died in his eighty-third year on October 25, 1956. A Life Member of the Medical Association of Georgia, Dr. Isler had practiced medicine in Meigs for 60 years.

Dr. Isler was born and reared near Edison. He was an active Mason and Shriner and took part in all phases of the work as long as his health permitted. He served as secretary of the Masons for 50 years. He was also a member of the Meigs Baptist Church.

Funeral services were held at the Meigs Baptist Church on October 25th; interment was in the Meigs cemetery. Masonic graveside rites were conducted by the Meigs Lodge; Shriners were honorary pallbearers.

Dr. Isler is survived by his wife, the former Miss Maude Sutton of Cairo; three brothers and three sisters.

Resolution

Whereas, the death of Dr. James N. Isler, October 25, 1956, has resulted in a severe loss to his many

patients and friends and has brought sorrow to the people who loved, trusted and honored him.

Whereas, his death will be a loss to the people of his community.

Be It Resolved, that the members of the Thomas-Brooks Medical Society feel the loss of a fellow member.

Be It Further Resolved, that a copy of these resolutions be put in the minutes of the Thomas-Brooks Medical Society, a copy be sent to the family of Dr. James N. Isler, and a copy be sent to the *Journal of the Medical Association of Georgia*.

SOCIETIES

The **THIRD DISTRICT MEDICAL SOCIETY** held its regular Fall meeting on November 8, 1956, in Cuthbert at the Cuthbert Recreation Center with the Randolph - Terrell Medical Society acting as host. John Gallemore, Perry, president of the Third District Medical Society, called the meeting to order, and the invocation was given by Willis Jordan, Columbus. J. C. Patterson, Cuthbert, gave the address of welcome, and Frank B. Schley, Columbus, responded to the address of welcome. Four scientific presentations were made as follows: Ralph E. Tiller of Columbus, spoke on the topic, "Convulsions"; Walter G. Thwaite, Columbus, presented a demonstration on "A Simpler and Improved Umbilical Cord Tie"; William G. Hamm, Atlanta, presented a paper on "Repair of Injuries to the External Male Genitalia"; and Frank Wilson, III, Leslie, reported on "Treatment of Systemic Lupus Erythematosus with Intramuscular Blood—Case Report". At the business session following the scientific presentation President Gallemore called on W. G. Elliott, Cuthbert, Councilor for the Third District, who reported on the activities in progress of the Council of the Medical Association of Georgia. Following Dr. Elliott's presentation, Hal M. Davison, Atlanta, president of the Medical Association of Georgia; W. Bruce Schaefer, Toccoa, president-elect of the M.A.G., and Mr. Milton D. Krueger, executive secretary, discussed various aspects of the Association's status and progress. A fellowship hour was held at 5:30 p.m. followed by dinner at 6:30.

New officers elected during the business session of the meeting are as follows: President, O. Thomas Gower, Cordele; Vice-president, Da-

vid Berman, Columbus; and, Secretary, T. Schley Gatewood, Americus, reelected.

The **FOURTH DISTRICT MEDICAL SOCIETY** held its Fall meeting November 7, 1956, at the Elks Club, Griffin. The scientific program held during the afternoon consisted of the following papers: "Congenital Agammaglobinemia," a case presentation by Grady E. Black, Griffin; "Differential Diagnosis of Symptomless Glycosuria", J. Render Turner, LaGrange; "Eyeground Studies", slide presentation, Jack L. Austin, Griffin; "Present Status of Chemotherapy in the Treatment of Cancer", Enoch Callaway, LaGrange. Also during the afternoon, two panels were presented, one on Cesarean Section and the other on Auto Accident Injuries. Following a social hour and dinner, the business meeting was held with J. W. Chambers, President, presiding. Hal M. Davison, President of the Medical Association of Georgia, and W. Bruce Schaefer, President-elect, each gave a short talk. The banquet speaker was Corbett Thigpen of Augusta, who presented a film on multiple personality.

The **FIFTH DISTRICT MEDICAL SOCIETY** met on November 1, 1956, to hear about the experiences of Lt. Col. John P. Stapp, the Air Force physician now known as the "fastest man on earth". Col. Stapp rode a rocket sled 632 miles per hour and then was braked to a dead stop in a little over a second in a test at Holloman Air Force Base, New Mexico. Col. Stapp is chief of the Aero Medical Field Laboratory there. He said that he escaped serious injury because he was properly fastened to the seat with nylon shoulder and leg straps and a lap belt; it is his belief that a great many traffic deaths and injuries could be prevented by increased use of seat belts in automobiles.

BIBB COUNTY MEDICAL SOCIETY met on November 6, 1956, at Pinebrook Inn. Speaker at the meeting was Harry B. O'Rear, Dean of the Medical College of Georgia and Professor of Pediatrics, who spoke on "The Problem of Pulmonary Hyaline Membrane Disease". At the previous meeting, held on October 2, 1957, Thomas Findley, Professor of Medicine at the Medical

(Societies)

College of Georgia, spoke on "The General Causes of Renal Failure" The society voted to endorse the Jenkins-Keogh bill which provides professional men with the opportunity of deducting 10 per cent of their income for investment in retirement insurance, tax free.

The members of the GEORGIA MEDICAL SOCIETY heard Col. Ralph M. Lechause, U.S.A.F., who is special weapons defense officer in the Office of the Surgeon General in Washington, speak on "Thermonuclear Weapons' Effects and Associated Medical Problems in Care of Mass Casualties" at their meeting in October. Dr. Lechause was formerly commander of the hospital at Hunter Air Force Base; he has been active in civil defense work since 1948.

The October meeting of the HABERSHAM COUNTY MEDICAL SOCIETY was held on October 2, 1956, at the Commercial Hotel, Cornelia. In attendance were T. N. Lumsden, J. J. Arrendale, John Carswell, F. O. Garrison, L. G. Hicks, Jr., and J. L. Walker. After the business session the members viewed a motion picture on "Sparine." The November 1st meeting was also held at the Commercial Hotel. Seven members and three guests were present to hear Sam H. Hay, Toccoa, speak on "Cardiac Arrhythmias: Their Diagnosis and Treatment".

WARE COUNTY MEDICAL SOCIETY had as speaker at its November meeting W. L. Pomeroy. He discussed vaginal hysterectomy and showed films of the technique of operation which is used by Gordon Johnson of Tulane University and which Dr. Pomeroy advocates. Floyd E. Davis, president of the society, presided at the November 1st meeting.

PERSONALS

Twenty-four Georgians were among the 1,000 surgeons inducted as new fellows of the American College of Surgeons at its meeting in October in San Francisco. They are as follows: ARTHUR J. CRUMBLEY JR., NATHAN I. GERSHON, WILLIAM E. GOODYEAR, THOMAS N. GUFFIN, THOMAS A. HARRIS, RICHARD E. KING, STEWART M. LONG, JOHN H. ROGERS, ROBERT A. SEARS, JAMES C. TANNER JR., JOHN P.

WILSON, CECIL M. COUVES and WILLIAM E. VAN FLEIT, all of Atlanta; JOHN H. ROBINSON III, Americus; ELDON L. CAFFERY, POMEROY NICHOLS JR., CAROL G. PRYOR and C. MARTIN RHODE, all of Augusta; ERWIN R. JENNINGS, Brunswick; BRUCE C. NEWSOM, Columbus; PETER BRANDES, Dublin; THOMAS H. WILLIAMS, Macon; ERNEST G. EDWARDS JR., Savannah; and CHARLES H. WATT JR., Thomasville.

First District

CURTIS G. HAMES, Claxton, attended the postgraduate course on cardiac arrhythmias given by the Emory University School of Medicine on October 19-20.

JAMES MOULTRIE LEE, Savannah, announces the opening of his office in Savannah for the practice of general and chest surgery. Dr. Lee is the son of the late LAWRENCE LEE and the brother of LAWRENCE LEE, JR., Savannah. He graduated from the Medical School of the University of Virginia and served with the U. S. Army Medical Corps. He interned at Baltimore City Hospital and had four years of training in surgery in Madison, Wisconsin. Dr. Lee's office is located at 722 Drayton Street; he and Mrs. Lee, the former Miss Jeanne Roney of Frederick, Md., live at 5463 Speir Street, Savannah.

Second District

J. C. STONE, Doerun, was the inspiration for a feature story in the *Weekly Moultrie Observer* of October 12, 1956. Dr. Stone, a Life Member of the Medical Association of Georgia, has practiced medicine in Doerun for 48 years, during which time he estimates that he has delivered well over 6,000 babies and attended to the ills of just about every family in Doerun. He was born in Forsyth County in August 1884. He attended Baylor University and the University of the South (Sewanee) and was graduated with degrees in medicine and pharmacy. He interned in Dallas and came from there to Doerun. Dr. Stone is a member of the Colquitt County Medical Society and the Methodist Church. He is also a Royal Arch Mason, member of the Order of Knights Pythias, and Fraternal Order of Eagles. Dr. and Mrs. Stone, the former Miss May Van Harrell of Doerun, have three children and five grandchildren.

FRANK E. THOMAS, Albany, president of the Georgia Pediatric Society, presided at the 24th Annual Meeting of the society held in Atlanta on October 25, 1956. The incoming president is STEPHEN C. REDD, Atlanta; LE ROY ANTROBUS, ALBERT RAUBER, and JOSEPH YAMPOLSKY, all of Atlanta, were in charge of the program. Guest speakers at the meeting were Hattie E. Alexander, associate professor of pediatrics at the College of Physicians and Surgeons, Columbia University; Milton J. E. Senn, professor of pediatrics at Yale University School of Medicine; and Irving Schulman, associate professor of pediatrics at Cornell University School of Medicine.

Third District

MAURICE F. ARNOLD, Hawkinsville, was installed as president of the Georgia Academy of General Practice at the annual meeting held in Savannah in October. Other new officers include: FRED H. SIMONTON, Chickamauga, president-elect; SAGE HARPER, Douglas, vice-president; BEN K. LOOPER, Canton, secretary-treasurer; and directors, CHARLES E. McARTHUR, Cordele; T. J. BUSEY, Fayetteville; M. J. SIMMONS, Decatur; and JOSEPH B. MERCER, Brunswick.

J. T. CHRISTMAS, Vienna, blew the lid off a town scandal when he addressed the Vienna Kiwanis Club on the subject of a municipal sewerage disposal plant. "The raw sewerage emptying into the creeks that surround Vienna make them an open sewer like something out of the Middle Ages," he said. Dr. Christmas' address climaxed a year of surveys and picture-taking, including pictures of the new disposal plants at Cordele and Rochelle. The estimated cost of the plant is \$250,000, with Vienna residents paying approximately \$80,000.

Royce Hobby, Ashburn, announces the opening of a clinic for the general practice of medicine on Main Street, Ashburn. Dr. Hobby was discharged from the U. S. Air Force on October 31st. He served as chief of surgical and obstetrical services at Ernest Harmon Air Force Base, Newfoundland. Dr. Hobby is a native of Ashburn and is married to the former Miss Jane Randolph Thomas of Richmond. They have two children, Randy, 18 months, and Stephen, three months.

(Personals)

A. J. KRAVTIN, Columbus, was chairman of the diabetes detection drive sponsored by the Muscogee County Medical Society during the month of November. Serving on the committee with Dr. Kravtin were C. D. JOHNSON and FLOYD C. JARRELL, JR., also of Columbus. Physicians in Columbus are cooperating with the American Diabetes Association in providing free screening tests for the general public.

Fourth District

ENOCH CALLAWAY, LaGrange, has been named to the national Board of Directors of the American Cancer Society. Dr. Callaway is director of Region III, and as such is the third Georgian on the Board, the others being J. ELLIOTT SCARBOROUGH, Emory University, and Mr. Rutherford B. Ellis, Atlanta. Dr. Callaway is director of the West Georgia Cancer Clinic, senior attending surgeon at City-County Hospital (LaGrange), and chairman of the Professional Education Committee of the Georgia Division of the American Cancer Society. He is a past president of the Medical Association of Georgia and of the Georgia Division of the Cancer Society.

In October, Dr. and Mrs. Callaway were hosts at luncheon following a committee meeting of the Georgia Section of the American College of Surgeons. The luncheon was held at Ida Cason Callaway Gardens, Chipley, and the following guests were present: Dr. and Mrs. BRUCE SCHAEFER, Toccoa; Dr. and Mrs. DUNCAN SHEPARD and their children, Margaret and Allen, Atlanta; Dr. and Mrs. JULIAN QUATTLEBAUM, Savannah; LESTER HARBIN, Rome; and Dr. and Mrs. KENNETH GRACE, Dr. and Mrs. HOLLIS HAND, LaGrange.

J. M. KELLUM, Thomaston, attended the meeting of the American College of Surgeons in San Francisco.

Fifth District

Mr. and Mrs. Charles A. Collier have announced the marriage of their daughter, Mrs. William B. Armstrong, the former Henrietta Collier, to GUY DARRELL AYER, JR., Atlanta. Dr. Ayer is the son of GUY D. AYER, Atlanta, and the late Mrs. Ayer. Dr. and Mrs.

Ayer, Jr., are residing at 563 West Paces Ferry Road, N. W., Atlanta

MAXWELL R. BERRY, Atlanta, addressed the American College of Gastroenterology in October at the college's annual meeting in New York. Dr. Berry presented his observations on the connection between the incidence of ulcers and existence of low blood sugar content. Dr. Berry stated that there is a significantly larger number of secretory cells in ulcer patients than in normal persons and there is a tremendous increase in acid production in the stomachs of patients with low sugar levels.

JOSEPH C. BROWN, Conyers, has been appointed to the Board of Directors for the Atlanta Tuberculosis Association. He will represent Rockdale County on the Board, which has representatives from Rockdale, Fulton and DeKalb Counties.

MILTON F. BRYANT, Atlanta, attended the annual meeting of the American College of Surgeons in San Francisco in October. He read a paper summarizing research completed by JOHN HOWARD, JACQUES BERBEN, and himself at Emory University.

JOHN C. CAMPBELL, Atlanta, was one of the participants in a panel discussion held on October 3rd at Cornell University Medical School, New York City. The subject of the discussion was "What Is the Role of the Family Doctor in the Treatment of the Neuroses and Psychosis?"

EUGENE B. FERRIS, Atlanta, head of the Department of Medicine of Emory University and Director of the Georgia Heart Association, has been elected to serve as a vice-president of the American Heart Association. Two other Georgians are on the Board of Directors, they are R. BRUCE LOGUE, Emory University, and CARTER SMITH, Atlanta. THOMAS FINDLEY, Professor of Medicine at the Medical College of Georgia, was selected by the Council for High Blood Pressure Research as a delegate to the national assembly of AHA.

The first annual meetings of the Georgia Gerontology Society was held at Emory University on November 2, 1956. The program featured reports on the situation in Georgia with regard to the aged and talks

by individuals who have visited and observed how several foreign countries are handling the increasing number of aged in the total population. EDWARD D. REISMAN, Atlanta, spoke on "Health and Medical Care"; R. C. WILLIAMS, Atlanta, spoke on "Institutional Care"; and HARRIET E. GILLETTE, Atlanta; Dr. and Mrs. Rollin Chambliss and B. O. Williams spoke on "Around the World with Gerontology".

TED F. LEIGH, Emory University, was technical advisor for a film entitled "First a Physician", a dramatic motion picture portraying the role of the radiologist on the medical team. The picture was produced by the Photo Products Division of du Pont in cooperation with the American College of Radiology. The movie, which is in color and runs 27 minutes, was premiered in September during the 57th Annual Meeting of the American Roentgen Ray Society in Los Angeles. It will also be shown at the December meeting of the Radiological Society of North America, in Chicago. Dr. Leigh represented the American College of Radiology Commission on Public Relations in serving as technical advisor during the filming in New York. The 16mm. film is available for showing to civic, school and medical groups, on request to the du Pont representative in each local area or to the College, 20 N. Wacker Drive, Chicago 6.

Sixth District

Attending the meeting of the Georgia Pediatric Society in Atlanta on October 25th were JOHN PAUL JONES, WILLIAM W. ORR, EDWIN R. WATSON, OSCAR S. SPIVEY, LARRY A. SCHWARTZ, CHARLES T. RUMBLE, and CHARLOTTE NEUBERG, all of Macon.

R. C. GOOLSBY, CHARLES T. RUMBLE, and EDWIN R. WATSON, Macon, attended the meeting of the American Academy of Pediatrics in New York from October 8th through 11th.

J. B. KAY, Byron; W. LYNN HICKS, Macon; GEORGE H. ALEXANDER, Forsyth; and E. C. McMILLAN, JR., Macon, attended the meeting of the Georgia Academy of General Practice in Savannah, October 17th and 18th.

HAROLD C. ATKINSON, Macon, attended the meeting of the

(Personals)

Georgia Diabetic Association in Savannah, October 19th.

Dr. and Mrs. WILLIAM L. BARTON, Macon, announce the birth of a son on October 24, 1956.

Attending a meeting of the Academy of Ophthalmology and Otolaryngology on October 15-19 were W. DEVEREAUX JARRAT, DUNCAN WALKER, JR., and BRASWELL N. COLLINS, Macon.

LEON J. GOODMAN, Macon, attended the Conference on Endocrinology and Metabolism at the University of Texas in Houston.

M. L. GREENE and J. H. PRITCHETT, Monticello, are building a doctors' building next door to the Benton Apartment House on West Greene Street in Monticello. It will be a one-story, brick veneer building with 10 rooms. Dr. Greene began practicing in Monticello in September 1951 and Dr. Pritchett in the spring of 1952. They have had joint offices on Greene Street in the business district of the town.

WILLIAM H. HOLDEN, Macon, presented a lecture to the Officers' Wives Club at Robins Air Force Base recently on his expeditions to British Guiana and the Upper Amazon. Dr. Holden has made five extensive trips into South America to obtain material for the American Museum of Natural History in New York City and to continue his medical studies among the aborigines. Dr. Holden is now director of the Department of Plastic Surgery at the Mason Hospital and regional director of the Civil Aeronautics Medical Association.

JOHN J. PILCHER, Wrens, has been appointed medical examiner for the northern section of Jefferson County.

Dr. and Mrs. LON KING, JR., Macon, announce the birth of a daughter on October 14, 1956. This is their fourth child, third daughter.

Seventh District

CECIL F. JACOBS, Dalton, has assumed the position of commissioner of health of the newly organized four-county area, Whitfield, Murray, Fanning, and Gilmer. Dr. Jacobs comes to Dalton from Jesup

where he was in private practice. He is a native of Waycross and attended public schools in Ware County. He is a graduate of The Citadel, Charleston, S. C., and the Medical College of Georgia, Augusta.

Edward L. King, Rome, has been named chief of surgery at Battey State Hospital succeeding JOHN L. SHEK who is going into private practice. SAM JOE ROBINSON, former resident in thoracic surgery, has been named a staff surgeon at Battey.

DON SCHMIDT, Cedartown, was the featured speaker at a recent meeting of the Cedartown Woman's Club. His topic was "America's Number One Health Problem—Learning, Understanding, Giving".

FRED H. SIMONTON, Chickamauga, has been elected chairman of the State Board of Health. He succeeds R. L. ROGERS, Gainesville.

Eighth District

At a recent Rotary Club luncheon in Valdosta the feature of the meeting was a panel discussion in which several physicians answered questions submitted by members of the club. On the panel were I. MALCOLM GIBSON, R. K. WINSTON, B. G. OWENS, F. G. ELDRIDGE, and R. L. STUMP, JR. JEFF AUSTIN acted as moderator.

ARTHUR M. KNIGHT, JR., Waycross, has been named a fellow in the American College of Cardiology. He is a director of the Georgia Heart Association.

The *Journal* wishes to express sympathy to J. A. LEAPHART, Sea Island, on the death of his brother, Dr. Edward P. Leaphart, of Milledgeville. Dr. Leaphart was on the staff of the Milledgeville State Hospital at the time of his death.

Ninth District

A doctors' panel discussion was featured at a recent meeting of the Cornelia (Ga.) Elementary School P-TA. The topic was, "We Hold the Keys to Children's Health". Several local physicians and MARTIN H. SMITH, Gainesville, composed the panel.

J. L. WALKER, Clarkesville, attended the 43rd Annual Meeting of the Georgia Tuberculosis Associa-

tion in Rome in September. He appeared on a panel "Coordination of Service and Facilities for Tubercular Patients".

Tenth District

JAMES W. BENNETT, Augusta pediatrician, was the speaker at a recent meeting of the North Augusta Mothers' Club. Dr. Bennett spoke on "Accident Prevention with the Pre-School Child".

A panel discussion of "faith healers" was held recently in the Talmadge Memorial Hospital, Augusta. The panel was composed of physicians and clergymen and centered around discussions of the validity of "miracles" reportedly worked by Oral Roberts and other faith healers. Physicians participating were C. MARTIN RHODE, THOMAS W. GOODWIN, and AUGUSTIN S. CARSWELL, all of Augusta.

Three members of the Department of Medicine of the Medical College of Georgia attended the Southeastern Regional Meeting of the American College of Physicians in Nassau, Bahamas. V. P. SYDENSTRICKER, chairman of the department, presented a paper on "Abnormal Hemoglobins". THOMAS FINDLEY, professor of medicine, discussed "Nephrosis".

ROBERT B. GREENBLATT, professor and chairman of the Department of Endocrinology at the Medical College, and SARAH L. CLARK, Augusta, attended the 8th Annual Postgraduate Assembly of the Endocrine Society in Houston, Texas, October 22-27.

HARRY B. O'REAR, dean of the faculty of the Medical College, attended the meeting of the Georgia Pediatric Society in Atlanta in October.

HOKE WAMMOCK, Augusta, took part in the annual meeting of the Georgia Division of the American Cancer Society in Atlanta.

George W. Smith, Augusta, read a paper before the meeting of the American College of Surgeons in San Francisco entitled, "The Treatment of Cervical Disc Lesions by an Anterior Disc Removal and Inter-Body Fusion". Also attending the meeting from Augusta were ROBERT G. ELLISON and HAROLD S. ENGLER.

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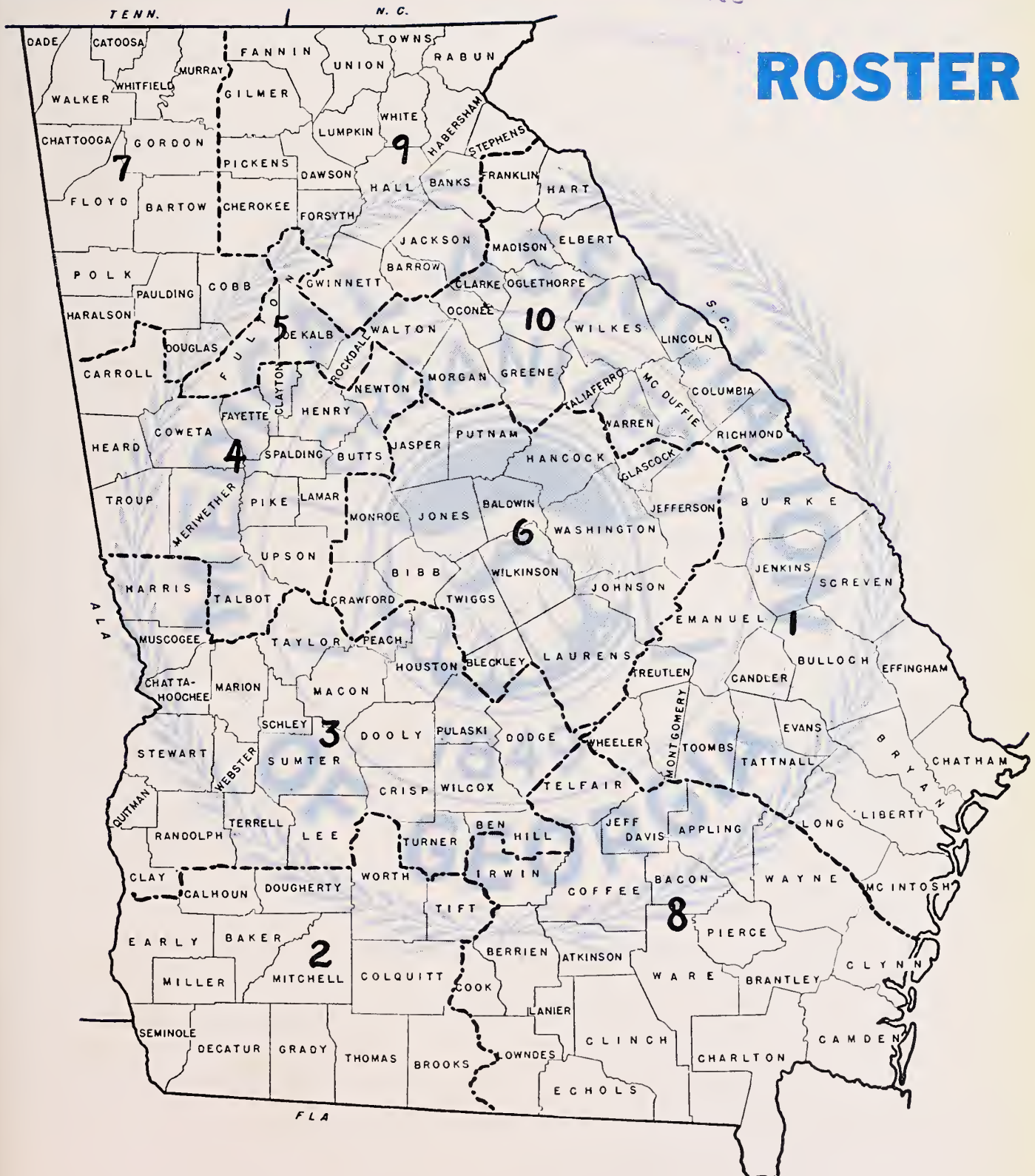
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ROSTER

of the

Medical Association

of Georgia

and

Woman's Auxiliary

1956

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Georgia Baptist Hospital

300 Boulevard, N. E. — ALpine 7861

Piedmont Hospital

551 Capitol Ave., S. W. — MU 8-1668

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272 Courtland St., N. E. — ALpine 4681

Emory University Hospital

Emory University, Ga. — DEarborn 1621

Ponce de Leon Infirmary

144 Ponce de Leon Avenue, N. E. — VErnion 7711

Medical Association of Georgia

Roster of Membership

This roster is made up of physicians whose names were forwarded to the headquarters office by the secretaries of the component county societies and whose dues were paid before January 1, 1956. Also included are the names of those physicians who are classified as Associate, Honorary, Life, or Scientific Members. Consult the county society secretary concerning omissions.

The official roster of members will be used as a basis for determining the number of delegates to the 106th Annual Session of the Medical Association of Georgia to be held in Atlanta, May 13-16, 1956. (One delegate for each 25 members or fraction thereof.)

The numbers and abbreviations found in the parentheses following each physician's name indicate the following:

(1) *Number*—the number indicates the society to which the physician belongs (Example: "1" signifies Altamaha Medical Society, "54" signifies Richmond County Medical Society, etc.) For complete key, see page 50.

(2) *Abbreviation following the number*—the letters indicate

the physician's specialty. (Example: "Pd" signifies Pediatrics; "S", Surgery). A complete list of specialty abbreviations is given below in bold print.

(3) *Second letter-abbreviation*—this indicates membership status. "Assoc" signifies Associate Member; "Hon", Honorary Member; "Life", Life Member; and "Sci", Scientific Member. If the physician is an active, dues-paying member, *no* abbreviation is used.

(4) "Dec" indicates that the member died during the year 1955.

EXAMPLE: "Doe, John D. (2-GP—Life-Dec), Milledgeville" would be read, John D. Doe (Life Member of Baldwin County Medical Society, in General Practice, deceased), from Milledgeville"; or "Jones, James C. (54-ObG), Greene St., Augusta" would be read, James C. Jones (Active Member of Richmond County Medical Society whose specialty is Obstetrics and Gynecology), his address is Greene Street, Augusta.

Following this listing of physicians by county societies, there is a complete alphabetical index of physicians.

S—Surgery
Pr—Proctology
NS—Neurological Surgery
Or—Orthopedic Surgery
PL—Plastic Surgery
Anes—Anesthesiology
Ob—Obstetrics
G—Gynecology
ObG—Obstetrics, Gynecology
Oph—Ophthalmology
ALR—Otolaryngology, Rhinology

OALR—Ophthalmology, Otolaryngology, Rhinology
D—Dermatology
U—Urology
I—Internal Medicine
Al—Allergy
C—Cardiovascular Disease
GE—Gastroenterology
Pul—Pulmonary Diseases
Pd—Pediatrics
P—Psychiatry

N—Neurology
PN—Psychiatry-Neurology
Path—Pathology
CP—Clinical Pathology
Bact—Bacteriology
R—Roentgenology, Radiology
PH—Public Health
Ind—Industrial Practice
HAd—Hospital Administration
PM—Physical Medicine

1—ALTAMAHA

Bedingfield, James Andrew (1-GP), Baxley
 Branch, W. D. (1-), Baxley
 Brown, J. B. (1-GP), Baxley
 Holt, J. T. (1-GP), Baxley
 Kennedy, F. D. (1-GP), Baxley
 Ohlmacher, Albert Phillip (1-S), Baxley
 Virusky, E. J. (1-S), N. Main St., Baxley

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 Burrell, Zeb, Jr. (2-I), Milledgeville
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 Cary, H. R. (2-GP), Milledgeville
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 Jordon, Charles G. (2-GP), Eatonton
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 Yarbrough, Y. H. (2-P—Life), Milledgeville

3—BANKS

Jolley, J. S. (3-GP), Homer

4—BARTOW

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 Horton, A. L. (4-GP—Life), Cartersville
 Howell, Wm. Harvey (4-GP), Cartersville
 Quillian, W. B., Jr. (4-GP), Cartersville
 Stanford, J. W. (4-GP), Cartersville
 Whatley, Lewis R. (4-GP), Cartersville
 Wofford, W. E. (4-GP), Cartersville

5—BEN HILL-IRWIN

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 Roberts, Ralph D. (5-GP), Fitzgerald
 Sams, William C., Jr. (5-GP), Ocilla
 Smith, J. E. (5-GP), Fitzgerald

Ward, Francis O. (5-GP), Fitzgerald
 Willcox, W. D. (5-GP), Fitzgerald
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6—BIBB

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 Westfall, Paul P. (7-GP), Dawsonville

8—BULLOCH-CANDLER-EVANS

Barksdale, J. H., Jr. (8-I), Statesboro
 Daniel, A. B. (8-S), Statesboro
 Daniel, J. W. (8-GP—Life), Claxton
 Deal, Albert M. (8-S), Statesboro
 Deal, Helen R. (8-Pd), Statesboro
 Deal, John D. (8-), Portal
 Floyd, W. E. (8-S), Statesboro
 Griffin, L. H. (8-GP), Claxton
 Hames, Curtis G. (8-), Claxton
 Lovett, K. S. (8-GP), Metter
 Lovett, Lindsey F. (8-GP), Metter
 McElveen, J. M. (8- —Life), Brooklet
 Meyer, George W. (8-), Metter
 Mooney, John, Jr. (8-S), Statesboro
 Moore, Ed L. (8-OALR), Statesboro
 Nevil, J. L. (8-GP), Metter
 Olliff, H. H. (8-GP), Register
 Simmons, W. E. (8-I), Metter
 Stapleton, C. E. (8-GP), Statesboro
 Swint, Robert H. (8-S), Statesboro
 Whiteside, J. H. (8-S), Statesboro

9—BURKE

Bargerion, E. A. (9-), Waynesboro
 Bent, H. F. (9- —Life), Midville
 Byne, J. M., Jr. (9-I), Waynesboro
 Green, Charles G. (9-GP), Waynesboro
 Hillis, W. W. (9- —Life), Sardis
 Hillis, W. W., Jr. (9-GP), Sardis
 Johnson, Julius T. (9-GP), Midville
 McCarver, W. C. (9- —Life—Dec.), Vidette
 Thompson, C., Jr. (9-GP), Waynesboro
 Thompson, Cleveland (9-S—Life), 305 6th St., Waynesboro

10—CARROLL-DOUGLAS-HARALSON

Aderhold, W. A. (10- —Life—Dec), Carrollton
 Allen, C. H. (10-), Bremen
 Allen, R. D. (10-), Tallapoosa
 Astin, Phil C., Jr. (10-GP), 13 W. Chandler St., Carrollton
 Barker, H. L. (10-GP—Life), Carrollton
 Bass, Eldred C. (10-GP), Carrollton
 Bowen, John L. (10-Pd), Carrollton
 Berry, Robert L. (10-GP), Villa Rica
 Denney, Roy L. (10-OALR), Carrollton
 Downey, W. P. (10-GP), Tallapoosa
 Hamilton, R. E. (10-), Douglasville
 Hamilton, Thomas E. (10-Ind), 1067 Banberry Rd., Marietta
 Holtz, Louis (10-GP), P. O. Box 265, Carrollton
 King, O. D. (10-), Bremen
 Martin, T. M., Jr. (10-), Bowdon
 Morgan, F. W. (10-), Douglasville
 Nutt, J. J. (10-GP), Bowdon
 Parks, Francis M. (10-GP), 144 Dixie Ave., Carrollton

Patrick, E. V. (10-), Carrollton
 Powell, B. C. (10- —Life), Villa Rica
 Powell, John E. (10-GP), Villa Rica
 Powell, John E., Jr. (10-GP), Villa Rica
 Prichett, John Henry, Jr. (10-), Bremen
 Reese, D. S. (10-OALR—Life), Carrollton
 Reeve, Thomas E., Jr. (10-S), Carrollton
 Roberts, O. W. (10- —Life), Carrollton
 Smith, W. P. (10-GP—Life), Bowdon
 Taylor, Thomas B. (10-), Douglasville
 Thomasson, W. E. (10-), Carrollton
 Vansant, C. V. (10-GP), Douglasville
 Vansant, Claude V., Jr. (10-GP), Douglasville
 Vansant, J. I. (10-GP), Villa Rica
 Watts, J. W. (10-GP), Bowdon
 Wilson, L. E. (10- —Life), Bowdon
 Worthy, W. Steve (10-ObG), 523 S. Tanner St., Carrollton

11—GEORGIA MEDICAL SOCIETY (Chatham)

Alexander, J. L. (11-S), 104 E. Gwinnett St., Savannah
 Amburgey, T. A. (11-Or), 202 E. Gaston St., Savannah
 Bedingfield, W. O. (11-), 14 W. Hull St., Savannah
 Bodziner, L. S. (11-ObG), 126 E. Gaston St., Savannah
 Bowden, Ralph O. (11-S), 24 W. Gaston St., Savannah
 Brawner, D. L. (11-ObG), 513 Whitaker St., Savannah
 Brown, C. T. (11-GP), Guyton
 Brown, F. Bert (11-Or), 22 W. Gaston St., Savannah
 Brown, Walter E. (11-GP), 14 W. Hull St., Savannah
 Buckhaults, W. W. (11-Oph), 103 E. Jones St., Savannah
 Center, A. H. (11-PN), 22 E. Taylor St., Savannah
 Chisholm, J. F. (11-OALR), 512 Abercorn St., Savannah
 Cirincione, V. J. (11-D), 800 Abercorn St., Savannah
 Clary, W. Upton (11-NS), 12 W. Jones St., Savannah
 Cole, W. A. (11-R—Life), 32 E. Taylor St., Savannah
 Cook, E. R., III (11-I), 220 E. 38th, Savannah
 Coward, Allen W. (11-), 17 E. Jones St., Savannah
 Crawford, W. B. (11-S—Life), 14 E. Taylor St., Savannah
 Crawford, W. B., Jr. (11-), 14 E. Taylor St., Savannah
 Dancy, Wm. R. (11-GE—Life), 102 W. Jones St., Savannah
 Daniel, John W., Jr. (11-GP), 5 E. Jones St., Savannah
 De Caradeuc, St. J. R. (11-OALR—Life), De Renne Apts., Savannah
 Demmond, E. C. (11-ObG), De Renne Apts., Savannah
 De Reamer, John W. (11-D), 118 E. Jones St., Savannah
 Drane, Robert (11-R), De Renne Apts., Savannah
 Duncan, J. Harry (11-Cph), 116 E. Jones St., Savannah
 Dunn, Laurence B. (11-GP), 220 Huntingdon St., Savannah
 Edwards, Ernest G., Jr. (11-Or), 512 Abercorn St., Savannah
 Egan, M. J. (11-S), 210 E. Liberty St., Savannah
 Elliott, J. L. (11-I), 212 E. Huntingdon St., Savannah

Epting, M. J. (11-S), 722 Drayton St., Savannah
 Faggart, G. H. (11-OALR), 18 W. Oglethorpe Ave., Savannah
 Fillingim, David B. (11-GP), 449 Abercorn St., Savannah
 Fleming, P. N. (11-OALR), 14½ W. Taylor St., Savannah
 Frech, H. C. (11-ObG), 427 Bull St., Savannah
 Freedman, L. M. (11-S), 1½ E. Gordon St., Savannah
 Freeman, Thomas R. (11-S), 513 Whitaker St., Savannah
 Fulmer, Wm. Henry (11-GP), 22 E. 34th St., Savannah
 Gleaton, E. N. (11-Pd), 204 E. Hall St., Savannah
 Goldenstar, G. W. (11-Oph), 106 E. Jones St., Savannah
 Gottschalk, Robert Bruce (11-S), 123 E. Jones St., Savannah
 Graham, Rufus E. (11-GP—Life), 212 E. Gaston St., Savannah
 Ham, Oscar Emerson (11-Pd), 2109 Abercorn St., Savannah
 Hardeman, Frank, Jr. (11-GP), De Renne Apts., Savannah
 Hoffman, Frank (11-ALR), 4 W. Liberty St., Savannah
 Holloman, J. J. (11-GP), 119 E. Jones St., Savannah
 Holton, C. F. (11-S), 606 E. 45th St., Savannah
 Hopkins, Anne (11-I), 4 E. Taylor St., Savannah
 Howard, Lee (11-Path), 202 E. Hall St., Savannah
 Howard, Lee, Jr. (11-Path), 202 E. Hall St., Savannah
 Howkins, John S. (11-), 113 E. Jones St., Savannah
 Johnson, G. Hugo, Jr. (11-), 126 E. Oglethorpe Ave., Savannah
 Jones, Jabez (11- —Life), 11 W. Gordon St., Savannah
 Kanter, W. W. (11-), 345 Bull St., Savannah
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 Kessler, Fred Otto, Jr. (11-GP), 802 Abercorn St., Savannah
 King, Ruskin (11-Pd), 10 W. Taylor St., Savannah
 Lang, G. H. (11-OALR—Life), 202 E. Liberty St., Savannah
 Lange, Stephen J. (11-), 12 Taylor St., Savannah
 Lawless, T. F. (11-), 12 E. Liberty St., Savannah
 Lee, Lawrence, Jr. (11-I), 113 E. Gwinnett St., Savannah
 Levington, H. L. (11-GP), 209 E. Gaston St., Savannah
 Lippitt, William H. (11-S), 224 E. Huntingdon St., Savannah
 Long, W. V. (11-S), De Soto Hotel, Savannah
 Lott, Oscar H. (11-GP), 111 E. Jones St., Savannah
 Lynn, S. C. (11-Pul), 124 E. Jones St., Savannah
 Maner, E. N. (11-OALR—Assoc), 101 E. 45th St., Savannah
 Martin, R. V. (11- —Life), 18 E. 31st St., Savannah
 Mazo, Milton (11-Pd), 8 E. Taylor St., Savannah
 McGoldrick, Thomas A., Jr. (11-I), 15 E. Gordon St., Savannah
 McLean, Jay (11-S), 612 Drayton St., Savannah

Metts, James C. (11-I), 110 W. Gaston St., Savannah
 Morrison, Howard J. (11-Pd), 444 Drayton St., Savannah
 Nash, D. A. (11-), 542 E. 49th St., Savannah
 Neville, R. L. (11-S), 11 W. Gordon St., Savannah
 Nichols, Fenwick T., Jr. (11-I), 102 E. Gwinnett St., Savannah
 Oliver, Robert Lee (11-S), De Renne Apts., Savannah
 Olmstead, G. T. (11-OALR—Life), 20 E. Taylor St., Savannah
 O'Neill, J. C. (11-), 202 E. Liberty St., Savannah
 Osborne, E. S. (11-OALR—Life), 19 E. Jones St., Savannah
 Osborne, W. W. (11-ObG), 24 E. Liberty St., Savannah
 Osteen, W. L. (11-Anes), 610 Anderson Ave., Savannah
 Otto, Walter W. (11-PH), 23 E. Charlton St., Savannah
 Pacifici, Joseph (11-), 2 E. Taylor St., Savannah
 Peterson, T. A. (11-GP), 11 W. Jones St., Savannah
 Pinholster, J. H. (11-S), 241 Abercorn St., Savannah
 Porter, J. E. (11-S), 128 E. Taylor St., Savannah
 Portman, H. J. (11-Pd), 9 E. Gordon St., Savannah
 Powers, Leander K. (11-GP), 29 E. Jones St., Savannah
 Prince, Charles L. (11-U), 2515 Habersham St., Savannah
 Puckett, Hollis E. (11-GP), 612 Abercorn St., Savannah
 Quattlebaum, J. K. (11-S), 24 W. Gaston St., Savannah
 Rabhan, Leonard J. (11-Pr), 314 E. Gaston St., Savannah
 Rabun, J. B. (11-R), 7 W. Gordon St., Savannah
 Redmond, C. G. (11- —Life), 701 Whitaker St., Savannah
 Redmond, C. R. A., 530 E. 49th St., Savannah
 Reichel, Hans A. (11-), 302 E. Huntingdon St., Savannah
 Righton, H. Y. (11-U—Life), 101 E. Waldburg St., Savannah
 Robinson, David (11-R), 104 E. Taylor St., Savannah
 Rollings, Harry E. (11-I), 120 E. Gaston St., Savannah
 Rosen, E. F. (11-OALR), 5 E. Gordon St., Savannah
 Rosen, Samuel F. (11-D), 4 E. Jones St., Savannah
 Rubin, Jacob (11-I), 350 Bull St., Savannah
 Salter, W. L. (11-GP), 2427 Abercorn St., Savannah
 Sax, Charles E. (11-ObG), 214 E. Gaston St., Savannah
 Scardino, Peter L. (11-U), 2515 Habersham St., Savannah
 Schley, Richard L., Jr. (11-Pd), 114 W. Gaston St., Savannah
 Schneider, M. M. (11-ObG), 126 Gaston St., E., Savannah
 Sharpley, H. F., Jr. (11-ObG), De Renne Apts., Savannah
 Sharpley, Helen (11-Ob), 1017 Abercorn St., Savannah
 Sharpley, John G. (11-S), De Renne Apts., Savannah
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Shepherd, Edwin C. (11-Pd—Assoc), 5th General Hospital, APO 154, New York, N. Y.
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 Smith, P. H. (11-ObG), 435 Abercorn St., Savannah
 Stalvey, J. K., Jr. (11-S), 114 E. Jones St., Savannah
 Stone, R. L. (11-Anes), 1121 Lexington Ave., Savannah
 Straight, George W. (11-), 304 E. Huntingdon St., Savannah
 Taylor, L. B. (11- —Life), 107 W. Huntingdon St., Savannah
 Titus, Norman E. (11-PM), 112 Jones St., W., Savannah
 Train, John Kirk, Jr. (11-ALR), 1107 Bull St., Savannah
 Upson, E. T. (11-S), 201 E. Hull St., Savannah
 Usher, Charles (11-S—Life), 6 E. Liberty St., Savannah
 Victor, Irving (11-U), 228 E. Huntingdon St., Savannah
 Victor, Jules, Jr. (11-I), 126 E. Taylor St., Savannah
 Waring, A. J., Jr. (11-Pd), De Renne Apts., Savannah
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 Waring, Thomas P. (11-Or), 905 E. Duffy St., Savannah
 Westerfield, C. W. (11-Anes), 101 Garrard Ave., Savannah
 Williams, A. F. (11-I), 423 Bull St., Savannah
 Williams, L. W. (11-S), 105 E. Jones St., Savannah
 Willoughby, Dan H. (11-I), 20-B W. Taylor St., Savannah
 Wills, Benjamin C. (11-P), 210 E. Gaston St., Savannah
 Wilson, W. D. (11-S), 104 W. Waldburg St., Savannah
 Winburn, James R., Jr. (11-S), 24 E. Liberty St., Savannah
 Withington, John C. (11-I), 106 W. Jones St., Savannah
 Youngblood, Samuel, Jr. (11-GP), 108 E. Taylor St., Savannah
 Zirkle, John G. (11-S), 722 Drayton St., Savannah

12—CHATTOOGA

Allen, John J. (12-GP), Trion
 Gist, Wm. T. (12-GP), Summerville
 Goodwin, H. A., Jr. (12-GP), Summerville
 Hyden, Wm. U. (12-), Trion
 Little, G. H. (12-GP), Trion
 Little, R. N. (12-), Summerville
 Martin, W. P. (12-GP), Summerville

13—CHATTAHOOCHEE

Bramblett, Rupert H., Jr. (13-), Rt. 3, Cumming
 Cain, Sylvester (13-GP), Norcross
 Chastain, J. R. (13-), Buford
 Ezzard, W. P. (13-I), Lawrenceville
 Hendrix, M. G. (13- —Life), Ball Ground
 Hutchins, Harry (13-GP), Buford
 Hutchins, W. J. (13-GP), Buford
 Kelley, D. C. (13-GP), Lawrenceville
 Lipscomb, W. E. (13- —Life), Cumming
 Mashburn, James S. (13-S), Cumming
 Mashburn, Marcus (13-GP), Cumming
 Mashburn, Marcus, Jr. (13-ObG), Cumming
 Mason, M. H. (13-GP), Duluth
 Mauldin, John W. (13-GP), Lawrenceville

Puett, W. W. (13-GP), Norcross
 Sims, Fayette A., Jr. (13-), Lawrenceville
 Smith, Reuben E. (13- —Assoc), Lawrenceville

14—CHEROKEE-PICKENS

Andrews, Chas. R., Jr. (14-S), Canton
 Boswell, T. C. (14-GP), Tate
 Coker, Grady N. (14-S), Canton
 Glover, O. G., Jr. (14-ObG—Assoc), Canton
 Hendrix, Arthur M. (14-GP), Canton
 Jones, R. T., III (14-GP), Canton
 Looper, Ben Keith (14-ObG), Canton
 Moore, R. M. (14- —Life), Waleska
 Nichols, W. H. (14-), Canton
 Perrow, G. H. (14-GP), Jasper
 Roper, C. J. (14-S), Jasper
 Roper, E. A. (14-GP), Jasper
 Vansant, T. J. (14-GP—Life), Woodstock
 Watkins, Charles B. (14-GP), Ellijay

15—CRAWFORD W. LONG

Barner, John L. (15-R), Athens General Hospital, Athens
 Bond, D. T. (15-GP), Danielsville
 Bonner, William H. (15-Pd), 130 W. Hancock Ave., Athens
 Boyd, Augustus B. (15-Anes), P. O. Box 774, Athens
 Brookshire, Paul F., Jr. (15-ALR), Medical Arts Bldg., Kingsport, Tenn.
 Brown, Wedford W. (15-PH), Athens-Clarke County Department of Health, Athens
 Bryant, C. H. (15-GP), Comer
 Byrd, H. G. (15-Ob), 1010 Prince Ave., Athens
 Crone, R. D. (15-Or), Rt. 4, Athens
 Crosby, William V. (15-ObG), 419 S. Milledge Ave., Athens
 Dover, Tom A. (15-Ob), 1010 Prince Ave., Athens
 Du Bose, Bolling S., Jr. (15-I), Southern Mutual Bldg., Athens
 Elder, John D. (15-ObG), 428 N. Milledge Ave., Athens
 Erwin, Goodloe Y. (15-I), 1010 Prince Ave., Athens
 Florence, Loree (15-Pd), Southern Mutual Bldg., Athens
 Callis, Anthony H. (15-I), Georgian Hotel, Athens
 Goldsmith, Lauren H. (15-Pd), Southern Mutual Bldg., Athens
 Green, Donarell R., Jr. (15-GP—Sci), Morton Bldg., Athens
 Green, James A. (15-S), 1010 Prince Ave., Athens
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 Harris, H. B. (15-G), 1010 Prince Ave., Athens
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 Hunnicut, J. A. (15-GP—Life), Southern Mutual Bldg., Athens
 Keller, A. Paul, Jr. (15-OALR), 1010 Prince Ave., Athens
 Kitchens, Wm. C. (15-I), 130 W. Hancock Ave., Athens
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 McPherson, John H. T. (15-S), 1010 Prince Ave., Athens

Meissner, Tom (Otto Walter) (15-Oph—Dec), 1010 Prince Ave., Athens
 Moss, W. L. (15- —Assoc), Jefferson Rd., Athens
 Neighbors, J. B., Jr. (15-I), 1010 Prince Ave., Athens
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 Robbins, John H. (15-PH), Infirmary, University of Georgia, Athens
 Simpson, John A. (15-Pd), 1010 Prince Ave., Athens
 Stegeman, John F. (15-I), 1010 Prince Ave., Athens
 Talmadge, Harry E. (15-S), 1010 Prince Ave., Athens
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 Traylor, James Bothwell (15-ObG), 419 S. Milledge Ave., Athens
 Warga, P. W. (15-Path), Athens General Hosp., Athens
 Wheelchel, G. O. (15-GP), Southern Mutual Bldg., Athens
 Whitley, L. L. (15-GP), 234 College Ave., Athens

16—CLAYTON-FAYETTE

Busey, T. J. (16-GP), Fayetteville
 Sams, Ferrol A., Jr. (16-GP), Fayetteville
 Sams, Helen F. (16-GP), Fayetteville
 Wallis, J. R. (16- —Life-Dec), Lovejoy
 Whiteman, Harold (16-GP), Jonesboro

17—COBB

Bagley, D. A. (17-GP—Life), Austell
 Benson, Earl B. (17-Anes), Kennestone Hosp., Marietta
 Benson, W. H., Jr. (17-I), 205 Lawrence St., Marietta
 Braley, Samuel U. (17-GP), Dallas
 Burleigh, Bruce D. (17-GP), 511 Clay St., Marietta
 Busch, John F. (17-PH), 310 McDonald St., Marietta
 Bussey, J. G. (17-S), Austell
 Cauble, George (17-), Acworth
 Clark, F. B. (17-GP), Austell
 Clark, Remer Y., Jr. (17-GP), 200 Roswell St., Marietta
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 Cogdell, B. H. (18-), Nicholls
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 Dillard, George P. (17-GP), Veterans Administration Hosp., Augusta
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 Fowler, R. W. (17-Pd), 204 Cherokee St., Marietta
 Garland, Charles M., Jr. (17-ObG), Smyrna
 Garrett, Luke G., Jr. (17-), Austell
 Gober, W. Mayes (17-Ob), 304 Cherokee St., Marietta
 Hagood, G. F. (17-GP), 204 Cherokee St., Marietta
 Hagood, M. M. (17-S), 204 Cherokee St., Marietta
 Henderson, Charles T. (17-S), 521 Campbell Hill St., Marietta
 Hodges, John M. (17-S), 301 Cherokee St., Marietta
 Inglis, E. P., Jr. (17-), 210 Cherokee St., Marietta
 Jennings, C. M. (17-I), 205 Lawrence St., Marietta
 Kaley, J. S. (17-S), 204 Cherokee St., Marietta

Lester, J. E. (17-PH), 205 S. Waddell, Marietta
 Levy, M. S. (17-Ind), Smyrna
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 Meaders, Henry D. (17-ObG), 513 Campbell Hill St., Marietta
 Mitchell, W. C. (17-GP), Smyrna
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 Weddington, W. H. (17-), Marietta

18—COFFEE

Bell, Eugene D. (18- —Assoc), Lafayette, Ind.
 Bush, James L. (18-OALR), Box 613, Douglas
 Clark, T. H. (18- —Assoc), Douglas
 Duley, Jack R. (18-), Nicholls
 Harper, Sage (18-GP), Douglas
 Jardine, Dan A. (18-S), Douglas
 Johnson, R. L. (18-GP), Douglas
 Joiner, H. G. (18-GP), Douglas
 Meeks, Calvin Stewart, Jr. (18-GP), Douglas
 O'Quinn, Silas E. (18-GP), Glenwood
 Parker, T. L. (18-S), Douglas
 Quillian, B. O. (18-GP—Life), Douglas
 Shellhouse, L. A. (18-GP—Life), Willacoochee
 Stapleton, Tommy K. (18-GP), Pearson
 Wallace, J. W. (18-I), Douglas

19—COLQUITT

Brannen, Cecil N. (19-GP), Moultrie
 Conger, P. D. (19-GP), Moultrie
 Fike, Rupert Howard (19-), Moultrie
 Flynn, James T., Jr. (19-OALR), Moultrie
 Fokes, Robert E., Jr. (19-OALR), Moultrie
 Funderburke, A. G. (19-GP), Moultrie
 Gay, Frank M. (19-GP), Moultrie
 Holmes, Edgar C. (19-S—Dec), Moultrie
 Joiner, R. M. (19-Pd), Moultrie
 McCoy, John F. (19-GP), Moultrie
 McGinty, W. R. (19-S), Moultrie
 McLeod, John W. (19-S), 223 S. Main St., Moultrie
 Paulk, J. R. (19-OALR), Moultrie
 Stegall, Robert E. (19-S), Moultrie
 Stone, J. C. (19- —Life), Doerun
 Whittendale, W. H. (19- —Life), Norman Park

20—COWETA

Arnold, J. H. (20-GP), Newnan
 Barksdale, C. R., Jr. (20-GP), Fairburn
 Bryant, James M., Jr. (20-), Newnan
 Elliott, Clifford C. (20-I), Sargent
 Farmer, Chas. W., Jr. (20-OALR), 43 Jefferson, Newnan
 Glover, Howard C., Jr. (20-Pd), Newnan
 Glover, N. B. (20-Pd), Newnan
 Hammond, G. W. (20-GP), Newnan
 Jackson, Bruce (20-), Rt. 1, Newnan

Jenkins, Ben H. (20-OALR), 2½ Court Square, Newnan
 Kinnard, George P. (20-U), 17 Carmichael St., Newnan
 McDonald, R. H. (20-S), Brown St., Newnan
 Mixon, George E. (20-GP), Palmetto
 Parks, Joseph W., Jr. (20-GP), 111 E. Broad St., Newnan
 Peniston, J. B. (20-), 35 Jefferson St., Newnan
 Powell, Jack H., Jr. (20-S), 35 Jefferson St., Newnan
 St. John, J. O. (20-GP), 41 Jefferson St., Newnan
 Tanner, W. H. (20-GP—Life), RFD No. 2, Newnan
 Wells, John G. (20-I), 41 Jefferson St., Newnan

21—DECATUR-SEMINOLE

Baxley, Harry B. (21-GP), Donalsonville
 Bellville, Chas. George (21-S), Bainbridge
 Bridges, E. Cleveland (21-I), Donalsonville
 Bridges, Henry A. (21-GP), Bainbridge
 Dupree, Thomas E. (21-GP), Bainbridge
 Ehrlich, M. A. (21-Pd), Bainbridge
 Gibson, Frank L. (21-S), Bainbridge
 Griffin, Edwin M. (21-GP), Riverside Clinic, Bainbridge
 Jenkins, H. B. (21-S), Donalsonville
 Moseley, E. E. (21-), Donalsonville
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 Wheat, R. F. (21-GP—Life), Bainbridge
 Willis, L. W. (21-GP), Bainbridge
 Woods, E. Ashby (21-GP), Bainbridge
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22—DEKALB

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 Beck, John E. (22-I), 356 W. Ponce de Leon Ave., Decatur
 Bloomer, William E. (22-GP), 520 Church St., Decatur
 Brawley, Wm. G. (22-Pd), 513 Derrell Ave., Decatur
 Brooks, Betty Ann (22-ObG), 720 Church St., Decatur
 Buchanan, L. C. (22-S), 374 W. Ponce de Leon Ave., Decatur
 Bundy, Eleanor E. J. (22-GP), 706 Church St., Decatur
 Carter, Henry G., Jr. (22-GP), 459 Candler Rd., Decatur
 Cooley, J. B. (22-), 2348 Glenwood Ave., S.E., Atlanta 17
 Cunningham, C. E. (22-GP), 231 E. Ponce de Leon Ave., Decatur
 Duncan, G. A. (22-GP), 603 Church St., Decatur
 Edwards, Frances K. (22-Pd), 112 N. McDonough St., Decatur
 Evans, J. Rufus (22-GP), Stone Mountain
 Fowler, C. H., Jr. (22-I), 3842 Glenwood Rd., Decatur
 Fristoe, John W., Jr. (22-ObG), 1282 S. Oxford Rd., N.E., Atlanta 7
 Gibbs, R. L., Jr. (22-I), 2561 N. Decatur Rd., Decatur
 Heard, John P. (22-GP), 231 E. Ponce de Leon Ave., Decatur

Holbrook, H. P. (22-GP), Tucker
 Hunt, A. H. (22-), Lithonia
 Kerr, Wm. K. (22-GP), Chamblee
 Lee, Howard B. (22-GP), 603 Church
 St., Decatur
 Leslie, John T. (22-Pd), 518 Marshall
 St., Decatur
 Litton, James H. (22-GP), Tucker
 Matthews, Lawrence P. (22-ObG), 1282
 S. Oxford Rd., N.E., Atlanta 7
 McCurdy, Willis T. (22-GP), Stone
 Mountain
 McGeachy, Thos. E. (22-GP), 520
 Church St., Decatur
 Mendenhall, W. A. (22-GP), Chamblee
 Mitchell, G. L. (22-I), 2561 N. Decatur
 Rd., Decatur
 Morgan, Frank E., Jr. (22-R), 405 W.
 Ponce de Leon Ave., Decatur
 Morse, Chester W. (22-GP), 348 W.
 Ponce de Leon Ave., Decatur
 Nardone, A. J. (22-S), 68 Avondale
 Rd., Decatur
 Patillo, Charles E. (22- —Assoc), 544
 E. Ponce de Leon Ave., Decatur
 Petrie, Eleanor Byers (22-PH), 304
 Wilton Dr., Decatur
 Pirkle, Quentin (22-S) 1593 Candler
 Rd., Brookhaven
 Powell, F. C. (22-I), 319 Church St.,
 Decatur
 Sanders, Floyd R. (22-GP), 603 Church
 St., Decatur
 Schreeder, John M. (22-), 2314 Park-
 ridge Crescent, Chamblee
 Shinall, Robert P. (22-GP), 231 E.
 Ponce de Leon Ave., Decatur
 Simmons, M. Freeman (22-GP), 380 W.
 Ponce de Leon Ave., Decatur
 Smith, W. P. (22-I), 319 Church St.,
 Decatur
 Smoot, Richard H. (22-S), 215 Church
 St., Decatur
 Spitzer, T. Q. (22-GP), Chamblee
 Statham, George W. (22-Pd), 341 W.
 Ponce de Leon Ave., Decatur
 Stewart, Thos. W. (22-GP), Lithonia
 Taylor, John Edwin, Jr. (22-Pd), 341
 W. Ponce de Leon Ave., Decatur
 Trotter, John F. (22-GP), 520 Church
 St., Decatur
 Tuggle, M. Virginia (22-I), 822 Colum-
 bia Dr., Decatur
 Vinson, T. O. (22-PH), DeKalb County
 Health Dept., 126 Trinity Pl., Decatur
 Walker, Mary E. (22-Pd), 112 N. Mc-
 Donough St., Decatur

23—DOUGHERTY

Armstrong, Edward S. (23-I), 413 C&S
 Bank Bldg., Albany
 Berg, Joseph L. (23-Oph), 121 Ogle-
 thorpe Ave., Albany
 Bowman, M. B. (23-S), 1009 N. Mon-
 roe St., Albany
 Cantrell, J. E. (23-GP), 121 Oglethorpe
 Ave., Albany
 Cook, W. S. (23-GP—Life), 238½ Pine
 Ave., Albany
 Dunn, Robert G., Jr. (23-R), Phoebe
 Putney Memorial Hosp., Albany
 Feild, W. M. (23-), 403 Broad Ave.,
 Albany
 Fountain, T. Gray (23-S), 403 Broad
 Ave., Albany
 Fowler, Mark W. (23-), 500-A N.
 Slappey Dr., Albany
 Hilsman, P. L. (23-ObG), 412 Third
 Ave., Albany
 Hollis, Charles D., Jr. (23-I), 1009 N.
 Monroe St., Albany
 Holman, C. M. (23-ObG), 707 N. Jef-
 ferson St., Albany

Inman, J. S., Jr. (23-ObG), 711 N. Mon-
 roe St., Albany
 Johnson, Thomas D. (23-I), 1009 N.
 Monroe St., Albany
 Lamb, Charles C. (23-GP), 403 Broad
 Ave., Albany
 Lanier, Lonnie Richard, Jr. (23-ObG),
 1009 Lanier St., Albany
 Lucas, I. M. (23-GP—Life), 222½
 Broad Ave., Albany
 Matthew, Robert A. (23-Anes), Phoebe
 Putney Hospital, Albany
 McCall, Charles S., Jr. (23-I), 412½
 Fourth Ave., Albany
 McDaniel, J. Z. (23-U), C&S Bank Bldg.,
 Albany
 McKemie, H. M. (23-S), 502 C&S Bank
 Bldg., Albany
 McKemie, W. Frank (23-), 108 N.
 Monroe St., Albany
 Merren, David D. (23-), C&S Bank
 Bldg., Albany
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 St., Albany
 Paschal, J. Dean (23-Pd), 717 N. Mon-
 roe St., Albany
 Rawls, Otis Grey (23-S), 403 Broad Ave.,
 Albany
 Redfearn, J. A. (23-I—Life), 121 Ogle-
 thorpe Ave., Albany
 Rhyne, Walter P. (23-OALR), 403
 Broad Ave., Albany
 Richardson, R. C. (23-OALR), 506 West
 Broad Ave., Albany
 Roberson, Phil E. (23-ObG), 810 N.
 Slappey Dr., Albany
 Russell, Paul T. (23-GP), 1009 N. Mon-
 roe St., Albany
 Seymour, Glenn E. (23-S), 412 Fourth
 Ave., Albany
 Sutton, James Mack, Jr. (23-Pd), 412
 Fourth Ave., Albany
 Thomas, Frank E. (23-Pd), 1009 N.
 Monroe St., Albany
 Thomas, N. R. (23-ObG—Life), 1009
 N. Monroe St., Albany
 Thompson, F. H. (23-Path), Phoebe Put-
 ney Hosp., Albany
 Truelock, Albert S., Jr. (23-S), 1009 N.
 Monroe St., Albany
 Tye, J. P. (23-S), 220 Broad Ave., Al-
 bany
 Wood, Frank F., Jr. (23-GP), 802 N.
 Monroe St., Albany

24—ELBERT

Arnold, McAlpin H. (24-GP), 46 Laurel
 Dr., Elberton
 Bailey, D. V. (24-GP—Life), 276 N.
 Oliver, Elberton
 Carnes, Wm. C. (24-), Elberton
 Johnson, A. S., Jr. (24-GP), Laurel Dr.,
 Elberton
 Johnson, A. S., Sr. (24-OALR—Life),
 46 Laurel Dr., Elberton
 Johnson, J. E., Jr. (24-), 211 E.
 Church St., Elberton
 Johnson, W. A. (24-), 49 College Ave.,
 Elberton
 Jones, Rembert C. (24-GP—Sci), 215
 Elbert St., Elberton
 Mattox, B. B. (24- —Assoc), 132 S.
 Oliver St., Elberton
 Mickel, Carey A., Jr. (24-S), 35-7 Chest-
 nut St., Elberton
 O'Neal, John B., III (24-S), 33 Chest-
 nut St., Elberton
 O'Neal, Phyllis J. (24-), 23 Chestnut
 St., Elberton
 Pool, Winford H., Jr. (24-GP), Elberton

Quinn, David E. (24- —Assoc), VA
 Hosp., Dublin
 Smith, A. C. (24-Life), 115 S. Mc-
 Intosh St., Elberton
 Smith, F. A. (24-), First Nat'l Bank
 Bldg., Elberton
 Thompson, D. N. (24-GP—Life), 49
 College Ave., Elberton
 Ward, George A. (24- —Life), Rt. 4,
 Elberton

25—EMANUEL

Brown, R. G. (25-GP), Swainsboro
 Frost, H. R. (25-GP), Swainsboro
 Moye, R. J. (25-GP), Adrian
 Powell, C. E. (25-), Swainsboro
 Smith, H. W. (25-Ob), Swainsboro

26—FLINT

Allen, Calvin F., Jr. (26-), University
 Hospital, Augusta
 Busbee, Perry G. (26-GP), Cordele
 Carter, Yancey F., Jr. (26-GP), Ashburn
 Christmas, Joseph T. (26-GP), Vienna
 Coleman, Otha K. (26-), Cordele
 Daves, V. C. (26-GP), Vienna
 Davis, E. B. (26-GP), Byromville
 Dean, Harry B. (26-), Norristown
 State Hosp., Norristown, Pa.
 Goss, Christopher C. (26-GP), Ashburn
 Goss, Woodrow (26-), Ashburn
 Gower, Orien T., Jr. (26-GP), Cordele
 Kitchens, O. W. (26-GP), Byromville
 Malloy, Martin L. (26-), Vienna
 McArthur, Charles E. (26-GP), Cordele
 Robinson, Robert S. (26-GP), Vienna
 Whelchel, A. J. (26- —Life), Cordele
 Williams, H. J. (26-OALR), Cordele
 Williams, L. E. (26-GP), Cordele
 Williams, P. L. (26-GP), Cordele
 Williams, P. L., Jr. (26- —Assoc), Cor-
 dele
 Wooten, L. O. (26-), Cordele

27—FLOYD

Andrews, Russell E. (27-ObG), 206 Hos-
 pital Cir., Rome
 Banister, W. G. (27- —Life), Rt. 2,
 Rome
 Battle, Lee H., Jr. (27-S), 306 West
 Bldg., Rome
 Black, Robert J. (27-Pd), Rome
 Blalock, Frank A. (27-Pul), Battey State
 Hosp., Rome
 Bosworth, E. L. (27-I), Harbin Clinic,
 Rome
 Brannon, Emmett S. (27-I), McCall
 Hosp., Rome
 Brock, Roy Crawford (27-S), Harbin
 Clinic, Rome
 Capo, James P. (27-Pul), Battey State
 Hosp., Rome
 Corpe, R. F. (27-S), Battey State Hosp.,
 Rome
 Crenshaw, Fred (27-Pul), Battey State
 Hosp., Rome
 Crow, H. E. (27-Pul), Battey State
 Hosp., Rome
 Culbreth, Ernest W. (27-), Lindale
 Davis, Ralph J. (27-S), Rome
 Dawson, Harry (27-), Shannon
 Dellinger, Raiden W. (27-S), 321 W.
 7th St., Rome
 Gafford, A. V. (27-OALR), Harbin
 Clinic, Rome
 Garner, J. S., Jr. (27-), 5 Cherokee
 St., Rome
 Garrard, J. L. (27- —Life), Rt. 2, Wade
 St., Rome
 Gilbert, Warren (27-GP), Harbin Clinic,
 Rome
 Hackett, Walter G. (27-S), Rome
 Harbin, Lester (27-S), Harbin Clinic,
 Rome

Harbin, R. M., Jr. (27-S), Harbin Clinic, Rome
 Harbin, Thomas S. (27-OALR), Harbin Clinic, Rome
 Harbin, W. P., Jr. (27-I), Harbin Clinic, Rome
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 Jenkins, O. W. (27-GP), Lindale
 Johnson, Ralph N. (27-S), McCall Hosp., Rome
 Ketchum, W. H. (27-Pul), Battey State Hosp., Rome
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 Moore, Cliff, Jr. (27-S), 409 S. Broad, Rome
 Moore, Clifford (27-GP—Life), Lindale
 Moss, T. H. (27-ObG), Rome
 Mull, J. H. (27-S), Rome
 Norton, J. H., Jr. (27-GP), Cave Spring
 Norton, R. F. (27-ObG), 10 Hospital Cir., Rome
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28—FRANKLIN

Brown, Stewart D., Jr. (28-GP), Royston
 Harris, Wesley W. (28-GP), Royston
 Poole, E. T. (28-GP), Lavonia
 Ridgway, Robert E. (28-GP), Royston
 Williams, John W., Jr. (28-GP), Lavonia

29—FULTON

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 Adams, H. M. S. (29-GP—Life), Candler Bldg., Atlanta 3

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 Agrin, Alfred (29-P), 1447 Peachtree St., Atlanta 9
 Aiken, W. S. (29-S), 1401 Peachtree St., N.E., Atlanta 9
 Akin, John T., Jr. (29-S), 716 Strickler Bldg., 1293 Peachtree St., N.E., Atlanta 9
 Alden, Herbert S. (29-D), 600 Strickler Bldg., 1293 Peachtree St., N.E., Atlanta 9
 Allen, E. A. (29-I), 384 Peachtree St., N.E., Atlanta 8
 Allgood, Pierce (29-O), 478 Peachtree St., N.E., Atlanta 8
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 Almond, Claude A. (29- —Assoc), 105 Pryor St., N.E., Atlanta 3
 Ambrose, Samuel S., Jr. (29-U), 34 Seventh St., N.E., Atlanta 8
 Amerson, James Richardson (29-S—Assoc), 36 Butler St., S.E., Atlanta 3
 Anderson, John M. (29-P), 478 Peachtree St., N.E., Atlanta 8
 Anderson, Sam (29-P), 478 Peachtree St., N.E., Atlanta 8
 Anderson, Thomas J., Jr. (29-I), 478 Peachtree St., N.E., Atlanta 8
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 Arnold, Harry D., Jr. (29-Oph), 235 Strickler Bldg., 1293 Peachtree St., N.E., Atlanta 9
 Arnold, W. A. (29- —Life), 365 Peters St., S.W., Atlanta 3
 Arp, C. Raymond (29-I), 207 Doctors Bldg., 478 Peachtree St., N.E., Atlanta 8
 Arteaga, Oliver (29-OALR), 152 Forrest Ave., N.E., Atlanta 3
 Arthur, J. F. (29-), 5 Forsyth St., N.W., Atlanta 3
 Askew, Rufus A. (29-Ind—Dec), 10 Pryor St., N.E., Atlanta 3
 Asken, Edward L., Jr. (29-Oph), 340 Boulevard, N.E., Atlanta 12
 Atkins, F. M. (29-I), 478 Peachtree St., N.E., Atlanta 8
 Atwater, John S. (29-I), 478 Peachtree St., N.E., Atlanta 3
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 Aven, C. C. (29-Pul), 3851 Roswell Rd., N.W., Atlanta 5
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 Ayer, Guy D. (29- —Life), 563 W. Paces Ferry Rd., N.W., Atlanta 5
 Bachmann, Geo. (29-PH—Assoc), 1088 Lullwater Rd., N.E., Atlanta 6
 Baggett, L. G. (29-S), 478 Peachtree St., N.E., Atlanta 8
 Bailey, M. K. (29-U), 384 Peachtree St., N.E., Atlanta 3
 Baird, J. B. (29- —Life), 62 28th St., N.E., Atlanta 9
 Baird, J. Mason (29-Oph), 235 Strickler Bldg., 1293 Peachtree St., N.E., Atlanta 9
 Baker, W. Pope (29- —Assoc), 979 Springdale Rd., N.E., Atlanta 6
 Bancker, Evert A., Jr. (29-I), 478 Peachtree St., N.E., Atlanta 8
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 Barnett, C. F., Jr. (29-I), 478 Peachtree St., N.E., Atlanta 8
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 Barnett, Stephen T., Jr. (29-ObG), 478 Peachtree St., N.E., Atlanta 8
 Barrineau, Charles E. (29- —Assoc), 4152 Caldwell Rd., Apt. 4, Brookhaven
 Barrow, J. Gordon (29-I), 1123 Gordon St., S.W., Atlanta 10
 Bartholomew, R. A. (29-Ob), 272 Boulevard, N.E., Atlanta 12
 Bartlett, Walter M. (29-I—Assoc), 125 Michigan Ave., Decatur
 Bateman, Gregory W. (29-), Grand Theatre Bldg., Atlanta 3
 Bateman, Needham B. (29-GP), 340 Boulevard, N.E., Atlanta 12
 Bateman, Wm. H. (29-ObG), 340 Boulevard, N.E., Atlanta 12
 Bauer, Heinz (29-Path—Assoc), Emory University Hosp., Emory University
 Bauer, Theodore J. (29- —Assoc), Medical Officer, C.W.C., 50 Seventh St., N.E., Atlanta 23
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 Beasley, Ernest W., Jr. (29-I), 734 Boulevard, N.E., Atlanta 8
 Bell, Fred M., Jr. (29- —Assoc), 36 Butler St., S.E., Atlanta 3
 Bellhouse, Helen W. (29-PH), 12 Capitol Square, S.W., Atlanta 3
 Bennett, Alfred M. (29-), 69 Butler St., S.E., Atlanta 3
 Bennett, Truett V. (29-ALR), 144 Ponce de Leon Ave., N.E., Atlanta 8
 Bennett, Wm. H. (29-U), 701 Strickler Bldg., 1293 Peachtree St., N.E., Atlanta 9
 Benson, H. Bagley (29-Pd), 509 Strickler Bldg., 1293 Peachtree St., N.E., Atlanta 9
 Benson, Marion T., Jr. (29-ObG), 704 Piedmont Ave., N.E., Atlanta 8
 Berger, Israel Reuben (29-R—Assoc), Lawson VA Hospital, Chamblee
 Berger, Louis (29-Oph), 950 W. Peachtree St., N.W., Atlanta 9
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 Bickers, Donald S. (29-NS), 710 Peachtree St., N.E., Atlanta 8
 Bishop, E. L. (29-Path), 384 Peachtree St., N.E., Atlanta 8
 Bishop, Linton H., Jr. (29-I), 478 Peachtree St., N.E., Atlanta 8
 Bivings, F. Lee (29-Pd), 20 Fourth St., N.W., Atlanta 8
 Bivings, Wm. Troy (29-S—Assoc), 756 Cypress St., N.E., Atlanta 8
 Blackford, L. Minor (29-I), 104 Ponce de Leon Ave., N.E., Atlanta 8
 Blaine, B. C. (29-I), 2018 Hollywood Rd., N.W., Atlanta 18
 Blalock, John C. (29-), 384 Peachtree St., N.E., Atlanta 8
 Blalock, Tully T. (29-I), 490 Peachtree St., N.E., Atlanta 3
 Blandford, W. C. (29-GP), Candler Bldg., Atlanta 3

- Bleich, J. K. (29-I), 478-79 Peachtree St., N.E., Atlanta 8
- Bloom, Walter L. (29-), 69 Butler St., S.E., Atlanta 3
- Blumberg, Max M. (29-I), 1208 W. Peachtree St., N.W., Atlanta 9
- Blumberg, Richard W. (29-Pd), 33 Ponce de Leon Ave., N.E., Atlanta 8
- Blumenthal, Irvin (29-S), 384 Peachtree St., N.E., Atlanta 8
- Boger, Richard E. (29-Pd), 509 Strickler Bldg., 1293 Peachtree St., N.E., Atlanta 9
- Bogosian, Armen (29- —Assoc), Third Army Headquarters, Fort McPherson
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- Boland, F. Kells, Jr. (29-S), 101 Third St., N.E., Atlanta 8
- Boland, J. H. (29-Or), 101 Third St., N.E., Atlanta 8
- Boling, Edgar (29-Pr), 490 Peachtree St., N.E., Atlanta 8
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- Boyd, Hartwell (29-ObG), 56 5th St., N.E., Atlanta 8
- Boyd, M. L. (29-U), 563 Capitol Ave., S.W., Atlanta 15
- Boynton, Charles E. (29- —Life), 39 Avery Dr., N.E., Atlanta 9
- Boynton, Estelle D. (29—N & P), 768 Juniper St., N.E., Atlanta 8
- Bracher, Allen Nelson (29- —Assoc), USAH, Fort McPherson
- Brackett, J. Gordon (29-ALR), 478 Peachtree St., N.E., Atlanta 8
- Brawner, A. F. (29-P), c/o Brawner's Sanitarium, Smyrna
- Brawner, James N. (29-P—Life), 2800 Peachtree Rd., N.W., Atlanta 5
- Brawner, James N., Jr. (29-P), 262 W. Wesley Rd., N.W., Atlanta 5
- Bregman, Larry (29-Pd), 950 W. Peachtree St., N.W., Atlanta 9
- Brewer, Spencer S., Jr. (29-I—Assoc), Duke University, Durham, N. C.
- Bridges, Glen J. (29-U), 384 Peachtree St., N.E., Atlanta 8
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- Brown, Samuel Y. (29-ObG), 718 Strickler Bldg., 1293 Peachtree St., N.E., Atlanta 9
- Brown, Stephen T. (29-U), 384 Peachtree St., N.E., Atlanta 8
- Brust, A. A. (29-I), 69 Butler St., S.E., Atlanta 3
- Bryan, William W. (29-R), 710 Peachtree St., N.E., Atlanta 8
- Bryant, Milton F., Jr. (29-S), 1211 W. Peachtree St., N.E., Atlanta 9
- Bunce, Allen H. (29-I), 368 Ponce de Leon Ave., N.E., Atlanta 8
- Burdine, Winston E. (29-P), 384 Peachtree St., N.E., Atlanta 8
- Burge, Dan (29-I), 21 Eighth St., N.E., Atlanta 9
- Burgess, Taylor S. (29-ALR), 618 Strickler Bldg., 1293 Peachtree St., N.E., Atlanta 9
- Burke, B. Russell (29-ALR), 490 Peachtree St., N.E., Atlanta 8
- Burnett, Stacy W. (29-Pd), 56 Fifth St., N.E., Atlanta 8
- Burns, Lloyd L. (29- —Assoc), 35 Linden Ave., N.E., Atlanta 8
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- Campbell, Wm. E., Jr. (29-), 384 Peachtree St., N.E., Atlanta 8
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- Carter, Sandy B. (29-I), 218 Strickler Bldg., 1293 Peachtree St., N.E., Atlanta 9
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31—GORDON

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 Ferrence, John A. (32-), Whigham
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36—PEACH BELT

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Adams, Thomas M. (36-), Montezuma
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38—JASPER

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39—JEFFERSON

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Farris, John J. (39-), Wadley
Pilcher, George S. (39-GP), Louisville
Pilcher, John J. (39-), Wrens
Pilcher, John J., Jr. (39-GP), Wrens
Revell, Walter J. (39-), Louisville
Williams, Charles Roy (39-GP), Wadley

40—JENKINS

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Mulkey, A. P. (40-), Millen
Mulkey, Q. A. (40-S), Millen

41—LAMAR

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44—McDUFFIE

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Wilson, Paul H. (44-GP), Thomson

45—MERIWETHER

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46—MITCHELL

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49—OCONEE

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 McGeary, W. C., Jr. (49-GP), Madison
 Middlebrooks, T. W. (49-), Union Point
 Nicholson, J. H. (49-S), Madison
 Parker, J. Lee (49-GP), Greensboro
 Porter, J. L. (49- —Life), Rutledge

Thornton, H. A. (49-GP), P. O. Box 326, Greensboro
 White, Edward Olin (49-GP), Madison
50—OCMULGEE
 Arnold, M. F. (50-GP), Taylor Memorial Hospital, Hawkinsville
 Baker, W. R. (50-S), Hawkinsville
 Batts, A. S. (50-), Hawkinsville
 Coleman, W. E. (50-GP), Hawkinsville
 Conner, D. H. (50-), Eastman
 Durham, W. P. (50-OALR), Abbeville
 Holder, F. P., Jr. (50-S), Eastman
 Massey, W. F. (50-GP), Chester
 Owens, J. D. (50-GP), Abbeville
 Smith, R. L. (50-GP), Cochran
 Steele, Virgil S. (50-OALR), Eastman
 Sylvester, Hart (50-), Hawkinsville

51—POLK

Blanchard, William (51-S), Cedartown
 Campbell, Richard P. (51-), Cedartown
 Chaudron, P. O. (51-S—Life), Cedartown
 Elliott, C. B. (51-S), Cedartown
 Goldin, Harold W. (51-GP), Rockmart
 Goldin, Robert B. (51-GP), Rockmart
 Good, John W. (51- —Life-Dec), Cedartown
 Hagan, J. H. (51-GP), Rockmart
 Lucas, W. H. (51-GP—Life), Cedartown
 McBryde, T. E. (51-Ind—Life), Rockmart
 McGehee, John M. (51-S), Cedartown
 Ross, Grace R. (51-GP), Cedartown
 Schmidt, Don (51-GP), 311 Cave Springs Rd., Cedartown
 Smith, Charles M. (51-GP), Rockmart
 Spanjer, Raymond F. (51-GP), Cedartown
 Styles, O. R. (51-), Cedartown
 White, George M. (51-), Rockmart

52—RABUN

Boyd, George H., Jr. (52-GP), Clayton
 Cain, Robert Thomas (52-GP), Clayton
 Dover, J. C. (52-GP), Clayton

53—RANDOLPH-TERRELL

Arnold, J. T. (53- —Life), Parrott
 Elliott, W. G. (53-GP), Cuthbert
 Kenyon, J. M. (53- —Life), Richland
 Martin, F. M. (53- —Life), Shellman
 Martin, Robert B., III (53-S), Cuthbert
 Martin, Walter D. (53-GP), Dawson
 Mayo, Earl A., Jr. (53-), Richland
 Patterson, J. C. (53-S), Cuthbert
 Pugh, C. M. (53-), Lumpkin
 Rogers, F. S. (53-GP—Assoc), Coleman
 Sims, A. R. (53-), Richland
 Sims, Fred E. (53-), Dawson
 Ward, John A. (53-GP), Monticello

54—RICHMOND

Agee, M. P. (54-S), 753 Broad St., Augusta
 Agostas, W. N. (54-I), 1413 Gwinnett St., Augusta
 Allen, Lane H. (54-), Medical College of Georgia, Augusta
 Bailey, Ann Anderson (54- —Assoc), 2320 Kings Way, Augusta
 Bailey, T. E. (54-Pd), 1111 Druid Park Ave., Augusta
 Barfield, William E. (54-ObG), 1467 Harper St., Augusta
 Battey, Alfred M. (54-S), 1445 Harper St., Augusta
 Battey, C. R. (54-S), 921 Greene St., Augusta
 Battey, L. L. (54-I), 1407 Gwinnett St., Augusta
 Battey, W. W. (54-S—Assoc), 1445 Harper St., Augusta
 Bazemore, J. Malcolm (54-D), 1467 Harper St., Augusta

- Beard, Byron (54-ObG), 1417 Gwinnett St., Augusta
- Bedingfield, W. R. (54-OALR), Southern Finance Bldg., Augusta
- Bedingfield, W. R., Jr. (54-I), Harlem Bell, J. E. (54-Pd), 1411 Gwinnett St., Augusta
- Bennett, J. W. (54-Pd), 1467 Harper St., Augusta
- Bernard, G. T. (54-S—Life), 204 13th St., Augusta
- Blitch, Pierce G., Jr. (54- —Assoc), University Hosp., Augusta
- Bohorfoush, J. G. (54-I), VA Hosp., Augusta
- Bowen, J. B. (54-S), 842 Greene St., Augusta
- Bowles, Lester L. (54-P), Medical College of Georgia, Augusta
- Boyd, Wm. S. (54-ObG), 1020 Greene St., Augusta
- Brittingham, John W. (54-I), 1345 Greene St., Augusta
- Brown, Stephen W. (54-R), 1467 Harper St., Augusta
- Brown, Thomas P. (54-GP), Thomasville
- Bryans, C. I., Jr. (54-ObG), 1526 Gwinnett St., Augusta
- Burdashaw, J. F. (54- —Assoc-Dec), 2571 Mount Auburn Ave., Augusta
- Burdashaw, Wm. J. (54-OALR), 718 Monte Sano Ave., Augusta
- Burdison, Wm. R. (54- —Assoc), VA Hospital, Augusta
- Burgamy, Clyde A. (54-), 1167 University Ave., Augusta
- Carswell, Augustin S. (54-Or), 1407 Gwinnett St., Augusta
- Carswell, Harold A. (54- —Assoc), 4011 Barcelona Dr., Oakland, Calif.
- Carter, Curtis H. (54-I), Medical College of Georgia, Augusta
- Carter, Harvey R. (54- —Assoc), University Hosp., Augusta
- Chandler, A. Bleakley (54-), Medical College of Georgia, Augusta
- Chandler, John L. (54-Or), 1467 Harper St., Augusta
- Chaney, Ralph H. (54-S), 1445 Harper St., Augusta
- Clary, Thos. L., Jr. (54-I), 842 Greene St., Augusta
- Cleckley, Hervey M. (54-P), University Hosp., Augusta
- Corbitt, Melvis O. (54-Ob), 1309 Holden St., Augusta
- Cranston, W. J. (54-I—Life), 1345 Greene St., Augusta
- Crichton, Robert B. (54-), 2620 Richmond Hill Rd., Augusta
- Daniel, Ernest F., Jr. (54- —Assoc), Barbot Apt., 3-A, Baker Ave., Augusta
- Davis, Abe J. (54-PH), 3039 Pine Needle Rd., Augusta
- DeVaughn, N. M. (54-I), 124 7th St., Augusta
- Dixon, Ellis H., Jr. (54-ObG—Assoc), 623 Greene St., Augusta
- Duncan, John A. (54-), Martinez
- Echols, Joseph M. (54-ObG), 1167 University Pl., Augusta
- Ellison, Robert G. (54-S), 1116 Kirk Pl., Augusta
- Engler, Harold S. (54-S), University Hosp., Augusta
- Evans, James P. (54- —Assoc), University Hosp., Augusta
- Everett, Theodore (54-U), 1467 Harper St., Augusta
- Faulkner, Alva A. (54-ObG), 1467 Harper St., Augusta
- Faulkner, John A. (54-Or), 1142 Druid Park Ave., Augusta
- Findley, Thomas (54-I), Medical College of Georgia, Augusta
- Flanagin, W. Stewart (54-PL), Medical Arts Bldg., Augusta
- Friedman, Charles (54-Or), 1136 Druid Park Ave., Augusta
- Fulghum, Thomas E. (54-OALR), 1939 Kissingbower Rd., Augusta
- Fuller, Wm. A. (54-I), 1403 Gwinnett St., Augusta
- Gallaher, B. Shannon (54-I), 1001 Hammond Dr., North Augusta, S. C.
- Goldberg, Ira (54-ObG), 1415 Gwinnett St., Augusta
- Goodwin, T. W. (54-S), 1467 Harper St., Augusta
- Grant, James D. (54-I), 842 Greene St., Augusta
- Gray, J. D. (54-I), 842 Greene St., Augusta
- Greenblatt, Robert B. (54-ObG), 1467 Harper St., Augusta
- Hair, Lawton Quinby (54-I), 1467 Harper St., Augusta
- Hamilton, Walton W. (54-R—Assoc), 2333 Kings Way, Augusta
- Hamilton, William F., Jr. (54-R), 1467 Harper St., Augusta
- Harper, Harry T., Jr. (54-I), 1467 Harper St., Augusta
- Harrell, H. P. (54-Pd), Southern Finance Bldg., Augusta
- Harrison, F. N. (54-ObG), 1136½ Druid Park Ave., Augusta
- Hastings, E. V. (54-Path), St. Joseph's Hosp., Augusta
- Haynes, Grady O. (54- —Assoc), VA Hosp., Augusta
- Henry, Charles G. (54-Or), 842 Greene St., Augusta
- Hensley, E. A. (54-), Gibson
- Hitchcock, J. P. (54-S), 1138 Druid Park Ave., Augusta
- Hock, Chas. W. (54-GE), 1467 Harper St., Augusta
- Holmes, L. P. (54-R), 1467 Harper St., Augusta
- Hopkins, Enon C. (54-D), 1467 Harper St., Augusta
- Howard, Thomas J. (54-GP), 401-2 Southern Finance Bldg., Augusta
- Hudson, Jack (54-GP), 2036½ Virginia Ave., Augusta
- Jennings, W. D. (54-GP—Assoc), Marion Bldg., Augusta
- Jennings, W. D., Jr. (54-S), Marion Bldg., Augusta
- Jones, G. Frank., Jr. (54-S), 1020 Greene St., Augusta
- Jungck, E. C. (54-), 1467 Harper St., Augusta
- Kay, James B., Jr. (54-U), 1419 Gwinnett St., Augusta
- Kelly, G. Lombard (54-P), 1445 Harper St., Augusta
- Kelly, Gordon M. (54-S), 1538 Gwinnett St., Augusta
- Kilpatrick, Chas. M. (54-OALR), Southern Finance Bldg., Augusta
- Kinser, George H. (54-), P. O. Box 894, Terre Haute, Ind.
- Klemann, Gilbert (54-I), 1403 Gwinnett St., Augusta
- La Motte, Irene F. (54- —Assoc), University Hosp., Augusta
- Lee, F. Lansing (54-I), 1433 Gwinnett St., Augusta
- Leitheiser, Karl A. (54-Pd—Assoc), P. O. Box 3418, Duke Hosp., Durham, N. C.
- Leonard, Robert (54-OALR), 1109 Tel-fair St., Augusta
- Levy, Jack H. (54-R), 1425 Gwinnett St., Augusta
- Levy, Theodore (54- —Assoc), 419 Foster Ave., Brooklyn, N. Y.
- Lewis, S. J. (54-OALR—Life), S. F. C. Bldg., Augusta
- Lokey, Julian L. (54-I—Assoc), Kingston, N. C.
- Luther, Charles G., Jr. (54-S), 1140 Druid Park Ave., Augusta
- Major, Robert C. (54-S), 842 Greene St., Augusta
- Mangiello, Louis O. J. (54-NS), 1467 Harper St., Augusta
- Manter, John T. (54-), Medical College of Georgia, Augusta
- Martin, John M. (54-I), 1401 Harper St., Augusta
- Massengale, L. R. (54-Pd), 1138 Druid Park Ave., Augusta
- Matthews, W. E. (54-OALR), 1467 Harper St., Augusta
- May, E. R. (54- —Life), Lincolnton
- McConnell, Bright (54-Or—Assoc), University Hosp., Augusta
- McGahee, Robert C. (54-Pd), 1429 Gwinnett St., Augusta
- McGinty, Howard C. (54-S), 1407 Gwinnett St., Augusta
- McInnes, George F. (54-PL), 1247 15th St., Augusta
- McKnight, Robert R. (54-Or), 1409 Gwinnett St., Augusta
- McLain, Ernest K. (54-Pul—Assoc), VA Hospital, Augusta
- McRae, D. R., Jr. (54-S), 1427 Gwinnett St., Augusta
- Mealing, H. G. (54-I), 301 Southern Finance Bldg., Augusta
- Michel, H. M. (54- —Assoc), 1229 Glenn Ave., Augusta
- Miller, Abraham (54-ObG), 1345 Greene St., Augusta
- Miller, John M. (54-I), 1138 Druid Park Ave., Augusta
- Milligan, King W. (54-I—Life), 942 Greene St., Augusta
- Mountain, G. W. (54- —Assoc), 1121 Monte Sano Ave., Augusta
- Mulherin, Charles M. (54-ObG), 1526 Gwinnett St., Augusta
- Mulherin, C. S. (54-S—Assoc), Keystone Apts., Augusta
- Mulherin, F. X. (54-GP—Life), 1345 Greene St., Augusta
- Mulherin, Joseph L. (54-S), 1467 Harper St., Augusta
- Mulherin, Philip A. (54-Pd), 1427 Harper St., Augusta
- Mullins, D. F. (54-Path), 1467 Harper St., Augusta
- Murphy, Alex T. (54-I), 1134 Druid Park Ave., Augusta
- Nichols, Pomeroy (54-NS), 1467 Harper St., Augusta
- Norvell, J. T. (54-GP), 1240 Greene St., Augusta
- O'Rear, Harry B. (54-Pd), Medical College of Georgia, Augusta
- Owings, Richard S. (54-Pd—Assoc), University Hospital, Augusta
- Palmer, John R., Jr. (54- —Assoc), USNAS, Green Cove Springs, Fla.
- Payne, R. F. (54-PH), Medical College of Georgia, Augusta
- Perkins, H. R. (54-OALR), 1110 Sou. Finance Bldg., Augusta

Persall, John T. (54-ObG), 1417 Gwinnett St., Augusta
 Phillips, Curtis, Jr. (54- —Assoc), Memorial Hosp., New York, N. Y.
 Phillips, Hayward (54-Anes), 1082 Bertram Rd., Augusta
 Philpot, W. K. (54-GP), 1345 Greene St., Augusta
 Phinizy, Irvine (54-I), Sou. Finance Bldg., Augusta
 Pinson, Harry D. (54-S), 1467 Harper St., Augusta
 Pou, Leo H., Jr. (54-Anes), Medical College of Georgia, Augusta
 Prather, Stuart H., Jr. (54-R), 842 Greene St., Augusta
 Pryor, Carol G. (54-ObG), 1467 Harper St., Augusta
 Pund, Edgar R. (54-Path), Medical College of Georgia, Augusta
 Reeves, Nathan (54-I), 1401 Harper St., Augusta
 Reeves, Ninette (54-P), 2804 Oakland Dr., Augusta
 Reilly, Enos J. (54-ObG), University Hosp., Augusta
 Rhodes, R. L. (54-S—Life), Southern Finance Bldg., Augusta
 Rinker, J. Robert (54-U), Medical College of Georgia, Augusta
 Risteen, W. A. (54-NS—Assoc), University Hosp., Augusta
 Roberts, S. M. (54-R—Assoc), 2818 Bergen Pl., Augusta
 Robertson, J. R. (54-U—Life), 1345 Greene St., Augusta
 Robison, William P. (54-P), University Hosp., Augusta
 Roule, J. Victor (54-OALR), 1467 Harper St., Augusta
 Rucker, J. T., Jr. (54-Anes), University Hosp., Augusta
 Rushia, E. L. (54-Anes), University Hosp., Augusta
 Scharnitzky, E. O. (54-I), 1262 Greene St., Augusta
 Sell, M. B., Jr. (54-GP), 1550 Gwinnett St., Augusta
 Sheppard, Walter L. (54-Path), Medical College of Georgia, Augusta
 Shepherd, Mason H. (54-S—Assoc), University Hosp., Augusta
 Sherman, J. H. (54-S), 1538 Gwinnett St., Augusta
 Shiver, Charles B. (54- —Assoc), 1103 Druid Park Ave., Augusta
 Silver, D. M. (54-), SFC Bldg., Augusta
 Skinner, James M. (54- —Assoc), University Hosp., Augusta
 Smith, C. C. (54-D), Southern Finance Bldg., Augusta
 Steed, William A. (54-OALR), 1122 Druid Park Ave., Augusta
 Stevenson, Gilbert M. (54-I), 2410 Comanche Rd., Augusta
 Sullivan, Daniel B. (54-S—Assoc), University Hosp., Augusta
 Sydenstricker, V. P. (54-I), University Hosp., Augusta
 Tanner, David E. (54-R—Assoc), 3216 Briarcliff Dr., Augusta
 Templeton, C. M. (54-GP), 1333 Harper St., Augusta
 Tessier, Claude E. (54-Pd), Masonic Bldg., Augusta
 Thigpen, Corbett (54-P), University Hospital, Augusta
 Thomas, David R., Jr. (54-I), 1467 Harper St., Augusta
 Thurmond, A. G. (54-ObG), 1345 Greene St., Augusta

Thurmond, J. W. (54-ObG), 1167 University Pl., Augusta
 Torpin, Richard (54-ObG), Medical College of Georgia, Augusta
 Volpitto, P. P. (54-Anes), University Hosp., Augusta
 Voyles, Walter R. (54- —Assoc), University Hosp., Augusta
 Wall, Bithel (35-U), 1134 Druid Park Ave., Augusta
 Wammock, Hoke (54-S), Medical College of Georgia, Augusta
 Wammock, Virgene S. (54-D), 3012 Fox Spring Rd., Augusta
 Waters, A. J. (54-Anes), University Hospital, Augusta
 Watson, W. G. (54-ObG), 1167 University Pl., Augusta
 Weeks, J. L. (54- —Assoc), Harlem
 Weeks, Richard B. (54-S), 1527 Gwinnett St., Augusta
 Wehs, Richard J. (54-Ind), Maxwell House, 814 10th and Greene St., Augusta
 Whelchel, Merritt C. (54-Oph), 1333 Harper St., Augusta
 White, C. A., Jr. (54-S), 1138 Druid Park Ave., Augusta
 White, W. O. (54-Oph), 1467 Harper St., Augusta
 Wilcox, Everard A. (54- —Life), P. O. Box 615, Beaufort, S. C.
 Wilkes, W. A. (54-Pd), University Hospital, Augusta
 Williams, David C., Jr. (54-U), 1345 Greene St., Augusta
 Williams, W. J. (54-S), 1405 Gwinnett St., Augusta
 Willis, C. H., Jr. (55- —Assoc), Washington Rd., Augusta
 Witham, A. Calhoun (54-I), Medical College of Georgia, Augusta
 Wright, Claude-Starr (54-I), Medical College of Georgia, Augusta
 Wright, Geo. W. (54-S), 1467 Harper St., Augusta
 Wright, Peter B. (54-Or), 502 E. Colonial Dr., Orlando, Fla.
 Wylie, M. H. (54-S), 1403 Gwinnett St., Augusta
 Yarbrough, J. F., Jr. (54-Anes), University Hosp., Augusta

55—SCREVEN

Evans, Harry C. (55-), Newington
 Freeman, James C. (55-), Sylvania
 Hawkins, Katrine Rawls (55-GP), Sylvania
 Hogsette, Gerald B. (55-S), Sylvania
 Lanier, L. Fielding (55-Pd—Life), Sylvania
 Simmons, William G. (55-GP), Sylvania

56—SOUTH GEORGIA

Austin, G. J., Jr. (56-Pd), Valdosta
 Bennett, Sybil C. (56-), Valdosta
 Bennett, Van B. (56-I), 1306 N. Patterson St., Valdosta
 Bird, Frank (56- —Life), Lake Park
 Brannen, J. H. (56-U), 1306 N. Patterson St., Valdosta
 Burdick, Bingley L. (56-GP), 707 N. Patterson St., Valdosta
 Burns, D. L. (56-GP), Valdosta
 Clements, Fred N. (56-GP), Adel
 Davis, Byron C. (56-Path), Pineview General Hosp., Valdosta
 Dismuke, James C. (56-GP), P. O. Box 409, Adel
 Eldridge, F. G. (56-R), Valdosta
 Gibson, I. Malcolm (56-I), 101½ W. Brookwood Dr., Valdosta
 Giddens, C. C. (56-GP), Valdosta
 Giddens, I. S. (56-GP), Lakeland

Johnson, A. M. (56-Pd), Valdosta
 Lindsey, W. F. (56-), Hahira
 Little, Alex G., Jr. (56-S), 1306 N. Patterson St., Valdosta
 Maughon, J. S. (56-GP), 107 W. Jane St., Valdosta
 Mixson, E. Harry (56-), Valdosta
 Mixson, Joyce F., Jr. (56-ObG), Valdosta
 Mixson, Joyce F., Sr. (56-GP—Life), Valdosta
 Newlin, Lucian K. (56-), Valdosta
 Oliphant, J. B. (56-), Adel
 Owens, B. G. (56-S), 1306 N. Patterson St., Valdosta
 Parrott, Jesse Lyle (56-GP), Hahira
 Perry, Robert E., Jr. (56-Path—Assoc), Chapel Hill, N. C.
 Peters, James S., Jr. (56-GP), Nashville
 Retterbush, W. C. (56-S), Valdosta
 Robbins, Allen I. (56-), Homerville
 Saunders, A. F. (56-ObG), Valdosta
 Sherman, Henry T. (56-I), 1310½ N. Patterson St., Valdosta
 Smith, E. J. (56-GP—Life), Hahira
 Smith, Fred C. (56-S), 1306 N. Patterson St., Valdosta
 Smith, J. Greg (56-PH), Lowndes County Dept. of Health, Valdosta
 Smith, J. R. (56-GP), Hahira
 Smith, T. H. (56-OALR—Life), Valdosta
 Stump, Robert L., Jr. (56-GP), Valdosta
 Thomas, Frank H. (56-Pr—Life), Valdosta
 Thompson, E. F. (56-OALR), 400 W. Central Ave., Valdosta
 Thompson, Emory F. (56-OALR), 400 W. Central Ave., Valdosta
 Turner, J. D. (56-GP), Nashville
 Turner, W. W. (56-GP), Nashville
 Wade, V. C. (56-), Valdosta
 Williams, T. C. (56-GP), Valdosta
 Winston, R. K. (56-Oph), 505 N. Patterson St., Valdosta
 Youles, Owen K., Jr. (56-ObG), 1306 S. Patterson St., Valdosta

57—SOUTHEAST GEORGIA

Aiken, Wm. W. (57-GP), Lyons
 Beddingfield, W. H. (57-GP), Vidalia
 Conner, H. I. (57-S), Vidalia
 Darby, V. L. (57-S), Vidalia
 De Jarnette, R. H. (57-), Vidalia
 Findley, C. W. (57-ALR), Vidalia
 Gross, O. S. (57-GP), Vidalia
 Hunt, James (57-GP), Mt. Vernon
 Kusnitz, Morris J., Jr. (57-), Alamo
 McArthur, John D. (57-), Lyons
 Mercer, J. E. (57-GP), Vidalia
 Moses, W. M. (57-), Uvalda
 Palmer, J. W. (57-), Ailey
 Yates, A. J., Jr. (57-GP), Soperton

58—SOUTHWEST GEORGIA

Baxley, W. C. (58-), Blakely
 Crowdis, James Hudson, Jr. (58-), Blakely
 Holland, S. P. (58-GP), Blakely
 Houston, W. H. (58-), Colquitt
 Lamson, Thomas H. (58- —Assoc), Arlington
 Martin, James B. (58-GP), Edison
 Merritt, Hinton J. (58-GP), Colquitt
 Merritt, James W. (58-GP), Colquitt
 Morgan, Horace L. (58-GP), Arlington
 Quattlebaum, Robert B. (58-GP), University Hosp., Augusta
 Rentz, Turner W. (58-), Colquitt
 Sharp, C. K. (58-GP), Arlington
 Shepard, W. O. (58-GP), Bluffton
 Standifer, J. G. (58-), Blakely

59—SPALDING

Austin, J. L. (59-OALR), Griffin
 Black, Grady E. (59-Pd), Griffin

Brandon, R. V. (59-GP), McDonough
Brown, George W. (59-R), Griffin
Clouse, John E., Jr. (59-GP), 682 S.
8th St., Griffin
Copeland, H. J. (59-ObG), Griffin
Cox, Joel E. (59-GP), Griffin
Ellis, H. C. (59-GP), McDonough
English, R. E. L. (59-GP—Life), 1109
Atlanta Rd., Griffin
Felder, Louis (59-I), McDonough
Fitzhugh, S. A. (59-Pd), Griffin
Floyd, T. J., Jr. (59-S), 232 W. Taylor
St., Griffin
Forrer, D. A. (59-OALR—Life), Griffin
Foster, Gurdon R., Jr. (59-GP), Mc-
Donough
Frye, Augustus H., Jr. (59-S), Griffin
Hammond, R. L. (59-GP), Jackson
Head, D. L., Sr. (59-S), Zebulon
Head, M. M. (59-GP—Life), Zebulon
Henry, George T. (59-GP), Barnesville
Hicks, W. G. (59-GP), Jackson
Howard, I. B. (59-GP—Life), William-
son
Howell, James C. (59-GP), Jackson
Hunt, K. S. (59-S), Griffin
Jones, A. P. (59-GP), P. O. Box 741,
Griffin
Kelley, J. Weldon (59- —Assoc), Grif-
fin
King, Harry C. (59-ObG), Griffin
King, Wm. R., Jr. (59-S), Griffin
Landham, J. W. (59-), 417 S. 8th St.,
Griffin
Montero, Enrique (59-Anes), 778 E.
College St., Griffin
Oshlag, Abraham M. (59-I), Griffin
Smaha, T. G. (59-G), Griffin
Stuckey, Ann D. (59-Pd), Griffin
Thomas, James R. (59-GP), Griffin
Walker, Geo. L. (59-I), 319 South
Eighth St., Griffin
Williams, Virgil B. (59-S), Griffin

60—STEPHENS

Ayers, C. L. (60-GP), Toccoa
Chaffin, E. F. (60-), Toccoa
Cleveland, Parish B. (60-Anes), Toccoa
Edge, J. H. (60- —Life), 356 Home
Park Ave., N.W., Atlanta 13
Good, W. H., Jr. (60-S), Toccoa
Harp, S. L. (60-GP), 809 E. Tugalo
St., Toccoa
Hay, S. H. (60-I), Toccoa
Hellenga, Irving D. (60-GP), Toccoa
McNeely, Henry H. (60-GP), Toccoa
Pittard, M. D. (60-GP), Toccoa
Schaefer, W. B. (60-S), Toccoa
Shiflet, Robert E. (60-GP), Toccoa
Singer, Arthur G. (60-R), Toccoa

61—SUMTER

Anderson, W. R. (61-GP), Americus
Bennett, W. F. (61-GP), Buena Vista
Boyette, L. S. (61-GP), Ellaville
Cheves, L. C., Jr. (61-GP), Montezuma
Durham, Bon M. (61-I), Americus
Fenn, Henry R. (61-GP), Americus
Gatewood, T. Schley (61-ObG), Amer-
icus
Logan, J. C. (61- —Life), Plains
McMath, Wm. Bates (61-OALR), Amer-
icus
Pendergrass, R. C. (61-R), 712 Crawford
St., Americus
Primrose, A. C. (61-GP), Americus
Robinson, John H., III (61-S), 205 S.
Lee St., Americus
Savage, C. P. (61-GP), Montezuma
Seay, E. Faxon (61-), Marshallville
Smith, H. A. (61-), Americus
Thomas, Russell (61-), Americus
Waldemayer, E. W. (61-GP), Americus
Wilson, Frank A., III (61-GP), Leslie

Wise, B. T. (61-S—Life), Rt. 1, Plains

62—TATNALL

Collins, J. C. (62-GP), Collins
Colson, A. C. (62-GP—Life), Glennville
Drake, Chas. H. (62-GP), Glennville
Hughes, J. M. (62-), Glennville
Jelks, Louis R. (62-S), Jelks Hospital,
Reidsville
Pinkston, A. G., Jr. (62-GP), Glennville
Strickland, L. V. (62-GP), Cobbtown

63—TAYLOR

Beason, Lewis (63-GP), Butler
Montgomery, R. C. (63-), Butler
Montgomery, R. C., II (63-), Butler
Sams, Frank H. (63-GP), Reynolds
Whatley, E. C. (63-), Reynolds

64—TELFAR

Born, W. H. (64-GP—Life), McRae
Fussell, J. K. (64-I), Rt. 1, Rhine
Jones, A. J. (64-GP—Life), Jacksonville
Maloy, C. J. (64-GP), McRae
Mann, Frank R. (64-GP), McRae
Mann, Frank R., Jr. (64-), McRae
McRae, D. B. (64-S), McRae
Parkerson, S. T. (64-GP), McRae
Smith, F. A., Jr. (64-GP), McRae

65—THOMAS-BROOKS

Baldwin, Marion A. (65-), Thomas-
ville
Bell, Rudolph F. (65-U), Thomasville
Cheshire, Howard L. (65-ObG), 602
Seixas St., Thomasville
Collins, J. J. (65-R), Thomasville
Daniel, Frank C. (65-S), Pavo
Davis, Eschol E. (65-GP), Meigs
Dillinger, George R. (65-I), Upchurch
Bldg., Thomasville
Isler, J. N. (65-GP—Life), Meigs
Jones, A. B., Jr. (65-GP), Quitman
King, J. T. (65-OALR), Thomasville
Levy, Tracy (65-I), USPHS Hospital,
Seattle, Wash.
Little, Frank A. (65-Anes—Assoc), VA
Hospital, Brookhaven
McCollum, William (65-GP), Thomas-
ville
Mims, Oscar M. (65-I), Thomasville
Mobley, John W. (65-D), Medical Bldg.,
Thomasville
Morton, John B. (65-P), Thomasville
Murphy, Fred E., Jr. (65-Or), Thomas-
ville
Neel, Julian B. (65-S), 207 E. Jackson
St., Thomasville
Palmer, J. I. (65-ObG), Thomasville
Pepin, Henry S. (65-GP), 602 E. Seixas
St., Thomasville
Reading, Herbert F. (65-GP), Thomas-
ville
Reid, J. W. (65-GP), Thomasville
Sanchez, S. E., Jr. (65-), Barwick
Saye, E. B. (65-Path), Thomasville
Shealy, L. M. (65-GP), 910 N. Court
St., Quitman
Shepard, Kirk (65-S), Gordon Ave.,
Thomasville
Shipp, C. C. (65-OALR), Thomasville
Smith, L. A. (65-S), Quitman
Stillwell, John D. (65-PH), Thomasville
Stinson, F. F., Jr. (65-U), 415 Myrtle
Dr., Thomasville
Taylor, Warren A. (65-S), Medical Bldg.,
Thomasville
Wahl, Ernest F. (65-I), Thomasville
Wall, C. K. (65-S), Thomasville
Wasden, Harry A. (65-S), Quitman
Wasden, Howell A., Jr. (65-GP), Pavo
Watt, C. H. (65-S), Thomasville
Watt, Charles H., Jr. (65-S), 900 Gor-
don Ave., Thomasville
Wine, Mervin B. (65-Al), Thomasville

66—TIFT

Bridges, W. L., Jr. (66-Pd), Tift Ave.,
Tifton
Edmondson, T. L. (66-GP), Tifton
Evans, E. L. (66-GP), Tifton
Fleming, C. A. (66-), Tifton
Flowers, Eugene Monroe (66-GP), Tif-
ton
Jones, R. E. (66-GP), Tifton
Lucas, Paul Warren (66-OALR), Tifton
Pickett, F. B. (66-GP—Life), Ty Ty
Pittman, Carl S. (66-), Tifton
Pittman, Carl S., Jr. (66-GP), Tifton
Shepard, J. L. (66-GP), Omega
Zimmerman, Chas. (66-GP), Tifton
Zimmerman, W. F. (66-GP), Tifton

67—TRI-COUNTY

(Liberty-Long-McIntosh)

Armistead, I. G. (67-GP), Townsend
Middleton, O. D. (67-GP), Ludowici
68—TROUP
Arnold, E. T., Jr. (68-GP), Hogansville
Avery, R. M. (68-OALR), LaGrange
Callaway, Enoch (68-S), LaGrange
Chambers, James W. (68-I), 304 Church
St., LaGrange
Clark, W. H. (68-S—Life-Dec), La-
Grange
Coward, Charles T. (68-S), 301 Broome
St., LaGrange
Easley, Curran S., Jr. (68-P), LaGrange
Fackler, William B., Jr. (68-I), La-
Grange
Fisher, George B. (68-), Franklin
Freeman, Thomas N. (68-GP), LaGrange
Grace, Kenneth D. (68-S), 206 Church
St., LaGrange
Grady, Henry Wiley (68-R), 304 Church
St., LaGrange
Hammett, H. H. (68-GP), LaGrange
Hammett, H. H., Jr. (68-OALR), La-
Grange
Hand, Hollis (68-S), LaGrange
Harvey, C. W. (68-GP—Life), Hogans-
ville
Hendricks, Willis M. (68-ObG), La-
Grange
Herault, Pierre C., Jr. (68-Anes), 109
Westwood Dr., LaGrange
Herman, E. C. (68-S), LaGrange
Holder, J. S. (68-S), LaGrange
Hutchinson, W. L. (68-ObG), 110
Church St., LaGrange
Jones, H. T. (68-), West Point
Lewis, James W. (68-Pd), LaGrange
McCall, W. R. (68-Anes—Life), 409
Hill St., LaGrange
McCulloh, Hugh (68-), West Point
Mitchell, J. T. (68-R), City-County Hos-
pital, LaGrange
Molyneaux, E. W. (68-GP), Hammett
Bldg., LaGrange
Morgan, J. C. (68-S—Life), West Point
Morgan, James C., Jr. (68-OALR), West
Point
Norman, Lewis G., Jr. (68-S), West
Point
O'Neal, R. S. (68-GP—Life), LaGrange
Park, Emory R. (68-GP—Life), La-
Grange
Phillips, W. P. (68-Ob), LaGrange
Prescott, Eustace H. (68-PH), Troup
County Dept. of Health, LaGrange
Taylor, John L. (68-GP—Life), Franklin
Turner, J. R. (68-), LaGrange
Whitehead, C. Mark (68-U), LaGrange
Williams, C. O. (68-GP—Life), West
Point

69—UPSON

Barron, H. A. (69- —Life), Thomaston
Blackburn, J. D. (69-Or), 211 Thurston
Ave., Thomaston

Dallas, R. E. (69-GP), 211 E. Thomaston St., Thomaston
 Garner, J. E. (69-GP), 311 W. Main St., Thomaston
 Gower, W. J. (69-GP), 211 E. Thompson St., Thomaston
 Grubbs, J. H. (69- —Life), Molena
 Harris, C. A. (69-), The Rock
 Head, D. L., Jr. (69-GP), E. Thompson St., Thomaston
 Kellum, J. M. (69-S), Thomaston
 McKenzie, J. M. (69-), Thomaston
 Mincey, Rollo J., Jr. (69-ObG), 211 E. Thompson St., Thomaston
 Sappington, T. A. (69-GP), S. Green St., Thomaston
 Scott, Morgan (69-), 101 Avenue F, Thomaston
 Tyler, Herbert D. (69-I), 612 W. Gordon St., Thomaston
 Woodall, F. M. (69-GP), 316 W. Gordon St., Thomaston
 Woodall, James A. (69-), 16 W. Gordon St., Thomaston
 Woodall, Wm. Pruitt (69-), 316 W. Gordon St., Thomaston

70—WALKER-CATOOSA-DADE

Adkins, Thomas E. (70-), Adams Rd., Rossville
 Alexander, L. L. (70-GP), Rossville
 Alsobrook, Thomas W. (70-I), Rossville
 Cochran, T. A. (70-GP), Ringgold
 Cornett, Murl (70-GP), Lafayette
 Derrick, Howard C., Jr. (70-GP), Lafayette
 Dietrich, Paul H. (70-), 48 East View Dr., Chattanooga, Tenn.
 Gardner, J. L. (70- —Dec), Sulphur Springs
 Hall, David P. (70-S), Vanderbilt University Hosp., Nashville, Tenn.
 Harmer, A. A. (70- —Assoc), Bonita Springs, Fla.
 Hoover, J. P. (70-GP), 211 Andrews St., Rossville
 Hutchison, Norton H. (70-GP), Trenton
 Johnson, E. G. (70-S), 201 Medical Arts Bldg., Chattanooga, Tenn.
 Jones, Robert T. (70-), Lafayette
 Killeffer, John J. (70-Or), Interstate Bldg., Chattanooga, Tenn.
 Kitchens, S. B. (70-GP), Lafayette
 Middleton, D. S. (70-GP—Life), Rising Fawn
 O'Connor, Frank L. (70-S), Rossville
 Patterson, Robert L. (70-D), 207 Interstate Bldg., Chattanooga, Tenn.
 Pope, Roy, Jr. (70-GP), Chickamauga
 Pruitt, Maurice C. (70-), 2209 Ross-ville Blvd., Chattanooga, Tenn.
 Shepard, Richard C., Jr. (70-GP), Lafayette
 Shields, H. F. (70-GP—Life), Chickamauga
 Simonton, Fred H. (70-GP), Chickamauga
 Sims, J. P. (70-), Tri-County Hosp., Ft. Oglethorpe
 Stephenson, Chas. W. (70-GP), Ringgold
 Terrell, Warren (70-GP), Ft. Oglethorpe
 Townsend, E. M. (70- —Life), Ringgold
 Vassey, G. C. (70-GP), Rossville
 Wheeler, Stanley D. (70- —Assoc), Box 752, Loma Linda, Calif.
 Williams, L. A. (70-GP), Ringgold

71—WALTON

Anderson, M. W. (71-GP), Social Circle
 Briscoe, C. D. (71-I), Monroe
 Defreese, Samuel (71-GP), Monroe

Everhart, Guy (71-), Loganville
 Floyd, Chas. S. (71-GP), Loganville
 Head, Homer (71-GP), Monroe
 Huie, Lynn M. (71-GP), Monroe
 Nunnally, Harry B. (71-GP), Monroe
 Stewart, Philip R. (71-S), Monroe
 Thompson, Ernest (71-PH), Monroe
 Wenzel, R. E. (71-), Social Circle

72—WARE

Adkins, H. T. (72-PH), Waycross
 Austin, William F. (72-), Woodbine
 Bates, W. B., Jr. (72-GP), Waycross
 Bradley, D. M. (72-), Waycross
 Bussell, B. R. (72-GP), Waycross
 Calhoun, W. C. (72-Ob), 707 Elizabeth St., Waycross
 Davis, Floyd E. (72-GP), 201 Nichols St., Waycross
 Deloach, A. W. (72-S), Waycross
 Ferrell, T. J. (72-S), Waycross
 Flanagan, W. M. (72-), Waycross
 Flesch, W. L. (72-U), Box 895, Waycross
 Goldman, Benj. (72-GP), Hazlehurst
 Goldwasser, Fred E. (72-GP), Alma
 Harden, W. E. (72-GP), P. O. Box 113, Waycross
 Hawkins, L. M. (72-), Blackshear
 Hendry, G. T. (72-GP—Assoc), Blackshear
 Hendry, Katherine McM (72-GP), Blackshear
 Hendry, Wm. A. (72-GP), Blackshear
 Hooker, James F. (72-PH), Waycross
 Jackson, Joseph M. (72-GP), McCoy-Jackson Hospital, Folkston
 Jacobs, Ivey (72-GP), Waycross
 Knight, A. M., Jr. (72-I), P. O. Box 899, Waycross
 Lee, Walter E., Jr. (72-GP), Ware County Hosp., Waycross
 Mason, Eugene A. (72-), Folkston
 Massey, Clayton M. (72-Pd), P. O. Box 751, Waycross
 McCollum, R. Roy, Jr. (72-), Kingsland
 McCoy, W. R. (72-GP), Folkston
 McGoogan, M. T. (72-S), Waycross
 Minchew, B. H. (72-OALR), Waycross
 Mixson, W. D. (72- —Life), Waycross
 Muecke, H. W. (72-Pd), Waycross
 Oden, John W. (72- —Life), 2026 14th St., N., St. Petersburg, Fla.
 Oden, Lewis H., Jr. (72- —Assoc), Tyndall Field, Panama City, Fla.
 Oden, T. E. (72- —Assoc), Blackshear
 Penland, J. E. (72-GP), Waycross
 Pierce, L. W. (72-U), Waycross
 Pomeroy, W. L. (72-S), Waycross
 Reavis, W. F. (72-U), Waycross
 Schneider, W. J. (72-), Folkston
 Seaman, H. Ansley (72-GP), Waycross
 Sharpe, W. W., III (72-GP), Alma
 Shuman, Vilda (72-Pd), Waycross
 Smith, Leo (72-OALR), Box 778, Waycross

Terry, D. B. (72-GP), Homerville
 Victor, Samuel (72-GP), Waycross
 Wynn, O. C. (72-GP—Sci), Waycross
 Yeomans, Neal F. (72-R), Waycross
 Youmans, C. R. (72-GP), Hazlehurst

73—WARREN

Cason, H. B. (73-GP), Warrenton
 Davis, A. W. (73-GP), Warrenton

74—WASHINGTON

Dillard, James Bascom (74-GP—Assoc), Davisboro
 Helton, B. L. (74-GP), Sandersville
 Helton, William S. (74-GP—Assoc), Sandersville
 Hurt, Marion W. (74-GP), Sandersville
 Lennard, O. D. (74-S), Sandersville

Lever, Joseph E. (74-GP), Sandersville
 McElreath, F. T., Jr. (74-GP), Tennesse
 Newsome, N. J. (74-I), Sandersville
 Newsome, Emory G. (74-GP), Sandersville
 Overby, Nicholas (74-OALR), Sandersville
 Rawlings, William (74-), Sandersville
 Rogers, O. L. (74- —Life), 204 S. Smith St., Sandersville
 Taylor, Ralph (74-GP), Davisboro

75—WAYNE

Barker, Henry S., Jr. (75-), Jesup
 Glover, D. H. G. (75-PH), Wayne County Dept. of Health, Jesup
 Harper, Fred M. (75-GP), Jesup
 Jacobs, Cecil F. (75-), 292 E. Bay, Jesup
 Leaphart, J. A. (75-I), Jesup
 Miller, Robert E. (75-), Jesup
 Pumpelly, Robert A. (75-GP), Jesup
 Yeomans, James W. (75-S), Jesup

76—WHITFIELD

Booser, Albert Marion (76-GP), Dalton
 Bradford, J. E. (76-), Spring Place
 Bradley, Paul L. (76-GP), 204 Waugh St., Dalton
 Bradley, R. H. (76-), Chatsworth
 Broadrick, G. L. (76-GP—Life), Dalton
 Butterfield, Donald L. (76-PH—Dec), P. O. Box 374, Dalton
 Carson, Harold B. (76-), Chatsworth
 Carson, W. P. (76-), Chatsworth
 Erwin, H. L. (76- —Life), Dalton
 McGhee, Earl T. (76-GP), Dalton
 Mullins, James N. (76-GP), Chatsworth
 Rollins, J. C. (76- —Life), 1211 W. Rugby Ave., College Park, Ga.
 Rosen, E. A. (76-GP), 215 Pentz St., Dalton
 Sams, Henry L. (76- —Life), Dalton
 Starr, Trammell (76-GP), Dalton
 Summerour, Brooke F. (76-Anes), Dalton
 Wells, David A. (76-GP), 203 Pentz St., Dalton
 Whitfield, T. W. (76-GP), 200 W. Waugh St., Dalton
 Wood, D. Lloyd (76-GP), 200 King St., Dalton
 Yeargin, Loyd C. (76-GP), Dalton

77—WILCOX

Bussell, J. A. (77- —Life), Rochelle

78—WILKES

Adair, M. C. (78-GP), W. Spring St., Washington
 Cheves, Harry L. (78-GP), 620 Sibley St., Union Point
 Cheves, H. L., Jr. (78-GP), Union Point
 Duggan, A. Dan (78-GP), Washington
 Nash, T. C. (78-), Philomath
 Pennington, Weems R. (78-GP), Lincolnton
 Pinizy, John (78-GP), Lincolnton
 Simpson, A. W. (78-GP—Life), Box 306, Washington
 Simpson, A. W., Jr. (78-), Washington
 Stephens, Robert G. (78-GP—Life), Washington
 Wills, C. E., Sr. (78-GP), Washington
 Wills, Charles E., Jr. (78-GP), Washington
 Wood, O. S. (78-GP—Life), Washington

79—WORTH

Bell, P. E. (79- —Life), Sylvester
 Crowe, Norman J. (79-GP), Sylvester
 Davis, H. G., Jr. (79-GP), Sylvester
 Jefford, T. C. (79- —Life), Sylvester
 Stoner, W. P. (79-GP), Sylvester
 Tracy, J. L., Jr. (79-GP), Sylvester

Index of Physicians

The numbers and abbreviations found in the parentheses following each physician's name indicate the following:

(1) *Number*—the number indicates the society to which the physician belongs (Example: "1" signifies Altamaha Medical Society, "54" signifies Richmond County Medical Society, etc.) For key, see page 50.

(2) *Abbreviation following the number*—the letters indicate the physician's specialty (Example: "Pd" signifies Pediatrics; "S", Surgery, etc.) A complete list of specialty abbreviations is given below in bold print.

(3) *Second letter-abbreviation*—this indicates membership status. "Assoc" signifies Associate Member; "Hon," Honorary Member; "Life", Life Member; and "Sci", Scientific Member. If the physician is an active dues-paying member, no abbreviation is used.

(4) "Dec" indicates that the member died during the year 1955.

For a member's complete address refer to the county society listing as indicated by the number in parentheses.

S—Surgery
Pr—Proctology
NS—Neurological Surgery
Or—Orthopedic Surgery
PL—Plastic Surgery
Anes—Anesthesiology
Ob—Obstetrics
G—Gynecology
ObG—Obstetrics, Gynecology
Oph—Ophthalmology
ALR—Otolaryngology, Rhinology

OALR—Ophthalmology, Otolaryngology, Rhinology
D—Dermatology
U—Urology
I—Internal Medicine
Al—Allergy
C—Cardiovascular Disease
GE—Gastroenterology
Pul—Pulmonary Diseases
Pd—Pediatrics
P—Psychiatry

N—Neurology
PN—Psychiatry-Neurology
Path—Pathology
CP—Clinical Pathology
Bact—Bacteriology
R—Roentgenology, Radiology
PH—Public Health
Ind—Industrial Practice
HAd—Hospital Administration
PM—Physical Medicine

A

Abbott, Osler A., Emory University (29-S)
 Abercrombie, T. F., Atlanta (29-Life)
 Acree, John W., Hiawassee (33-GP)
 Acree, M. A., Calhoun (31-)
 Adair, M. C., Washington (78-GP)
 Adams, C. R., Atlanta (29-GP)
 Adams, Charles C., Atlanta (29-GP)
 Adams Charles D., Atlanta (29-D)
 Adams Elizabeth K., Emory University (29-I—Assoc)
 Adams, Guy H., Atlanta (29-I)
 Adams, H. M. S., Atlanta (29-GP—Life)
 Adams, Harold W., Atlanta (29-S)
 Adams, J. Fred, Montezuma (36-GP)
 Adams, James K., Jefferson (37-)
 Adams, Thomas M., Montezuma (36-)
 Aderhold, W. A., Carrollton (10- —Life-Dec)
 Adkins, H. T., Waycross (72-PH)
 Adkins, Thomas E., Rossville (70-)
 Agee, M. P., Augusta (54-S)
 Agnor, E. B., Atlanta (29-I)
 Agostas, W. N., Augusta (54-I)
 Agrin, Alfred, Atlanta (29-P)
 Aiken, W. S., Atlanta (29-S)
 Aiken, William W., Lyons (57-GP)
 Akin, John T., Jr., Atlanta (29-S)
 Alden, Herbert S., Atlanta (29-D)
 Alexander, G. H., Forsyth (6-GP)
 Alexander, J. L., Savannah (11-S)
 Alexander, L. L., Rossville (70-GP)
 Allen, C. H., Bremen (10-)
 Allen, Calvin F., Jr., Augusta (26-)
 Allen, E. A., Atlanta (29-I)
 Allen, E. W., Milledgeville (2-P)
 Allen, H. D., Jr., Milledgeville (2-P)
 Allen, H. H., Decatur (22-GP)
 Allen, John J., Trion (12-GP)
 Allen, Lane H., Augusta (54-)
 Allen, R. D., Tallapoosa (10-)
 Allen, W. P., Woodbury (45-)
 Allgood, Pierce, Atlanta (29-Or)
 Allison, G. G., Atlanta (29-U)
 Almand, Claude A., Atlanta (29- —Assoc)
 Alsobrook, Thomas W., Rossville (70-I)
 Althisar, Henry M., Thomson 44-GP)
 Ambrose, Samuel S., Jr., Atlanta (29-U)

Amburgey, T. A., Savannah (11-Or)
 Amerson, James R., Atlanta (29-S—Assoc)
 Anderson, J. C., Macon (6-S—Life)
 Anderson, John M., Atlanta (29-P)
 Anderson, M. W., Social Circle (71-GP)
 Anderson, Robert T., Dublin (42-GP)
 Anderson, Sam, Atlanta (29-P)
 Anderson, Thomas J., Jr., Atlanta (29-I)
 Anderson, W. R., Americus (61-GP)
 Andrews, Charles R., Jr., Canton (14-S)
 Andrews, Russell E., Rome (27-ObG)
 Ansley, R. B., Decatur (22-GP)
 Antrobus, Leroy C., Atlanta (29-Pd)
 Applewhite, J. D., Macon (6-)
 Arline, T. J., Cairo (32- —Life)
 Armistead, I. G., Townsend (67-GP)
 Armstrong, Edward S., Albany (23-I)
 Armstrong, William B., Atlanta (29-ALR—Dec)
 Arnold, E. T., Jr., Hogansville (68-GP)
 Arnold, Harry D., Jr., Atlanta (29-Oph)
 Arnold, J. H., Newnan (20-GP)
 Arnold, J. T., Parrott (53- —Life)
 Arnold, M. F., Hawkinsville (50-GP)
 Arnold, McAlpin H., Elberton (24-GP)
 Arnold, W. A., Atlanta (29- —Life)
 Arp, C. Raymond, Atlanta (29-I)
 Arrendale, Joe J., Cornelia (33-GP)
 Arteaga, Oliver, Atlanta (29-OALR)
 Arthur, J. F., Atlanta (29-)
 Artime, Manuel E., Clarkston (22-GP)
 Askew, Rufus A., Atlanta (29-Ind—Dec)
 Askren, Edward L., Jr., Atlanta (29-Oph)
 Astin, Phil C., Jr., Carrollton (10-GP)
 Atkins, F. M., Atlanta (29-I)
 Atkinson, H. C., Macon (6-I)
 Atwater, John S., Atlanta (29-I)
 Austin, A. C., Decatur (29-Pd)
 Austin, G. J., Jr., Valdosta (56-Pd)
 Austin, J. L., Griffin (59-OALR)
 Austin, William F., Woodbine (72-)
 Aven, C. C., Atlanta (29-Pul)
 Avera, Bertram Price, Jr., Dublin (42-I—Assoc)
 Avera, J. B., Brunswick (30-S)
 Avery, R. M., LaGrange (68-OALR)
 Ayer, G. Darrell, Jr., Atlanta (29-Path)
 Ayer, Guy D., Atlanta (29- —Life)
 Ayers, C. L., Toccoa (60-GP)

B

Bachmann, George, Atlanta (29-PH—Assoc)
 Baggett, L. G., Atlanta (29-S)
 Bagley, D. A., Austell (17-GP—Life)
 Bailey, Ann Anderson, Augusta (54- —Assoc)
 Bailey, D. V., Elberton (24-GP—Life)
 Bailey, L. A., Milledgeville (2-S)
 Bailey, M. K., Atlanta (29-U)
 Bailey, T. E., Augusta (54-Pd)
 Baird, J. B., Atlanta (29- —Life)
 Baird, J. Mason, Atlanta (29-Oph)
 Baker, W. R., Hawkinsville (50-S)
 Baker, W. Pope, Atlanta (29- —Assoc)
 Baldwin, Marion A., Thomasville (65-)
 Bancker, Evert A., Jr., Atlanta (29-I)
 Banister, W. G., Rome (27- —Life)
 Banks, George T., Fairmount (31- —Life)
 Banks, Rafe, Jr., Gainesville (34-U)
 Barfield, William E., Augusta (54-ObG)
 Barger, E. A., Waynesboro (9-)
 Baria, William Homer, Charleston, S. C. (29- —Assoc)
 Barker, H. L., Carrollton (10-GP—Life)
 Barker, Henry S., Jr., Jesup (75-)
 Barksdale, C. R., Jr., Fairburn (20-GP)
 Barksdale, J. H., Jr., Statesboro (8-I)
 Barner, John L., Athens (15-R)
 Barnes, John J., Atlanta (29-ObG)
 Barnes, R. C., Byron (6-GP)
 Barnes, Waddell, Macon (6-I)
 Barnes, Walter P., Jr., Macon (6-Or)
 Barnett, C. F., Jr., Atlanta (29-I)
 Barnett, J. C., Jr., St. Louis, Mo. (29-NS)
 Barnett, Stephen T., Jr., Atlanta (29-ObG)
 Barnett, W. R., Calhoun (41- —Life-Dec)
 Barrett, Clara, Atlanta (33-)
 Barrineau, Charles E., Brookhaven (29- —Assoc)
 Barron, H. A., Thomaston (69- —Life)
 Barrow, J. Gordon, Atlanta (29-I)
 Bartholomew, R. A., Atlanta (29-Ob)
 Bartlett, Walter M., Decatur (29-I—Assoc)
 Barton, William L., Macon (6-ALR)
 Bass, Eldred C., Carrollton (10-GP)

- Bateman, Gregory W., Atlanta (29-)
 Bateman, Needham B., Atlanta (29-GP)
 Bateman, William H., Atlanta (29-ObG)
 Bates, Floyd E., Chipley (47-GP)
 Bates, W. B., Jr., Waycross (72-GP)
 Battey, Alfred M., Augusta (54-S)
 Battey, C. R., Augusta (54-S)
 Battey, L. L., Augusta (54-I)
 Battey, W. W., Augusta (54-S—Assoc)
 Battle, Lee H., Jr., Rome (27-S)
 Batts, A. S., Hawkinsville (50-)
 Bauer, Heinz, Emory University (29-Path—Assoc)
 Bauer, Theodore J., Atlanta (29- —Assoc)
 Baugh, James E., Milledgeville (2-GP)
 Baxley, Harry B., Donalsonville (21-GP)
 Baxley, W. C., Blakely (58-)
 Baxley, W. W., Macon (6-S)
 Bazemore, J. Malcolm, Augusta (54-D)
 Bazemore, W. L., Macon (6-U)
 Beach, Bessie Mae, Columbus (47-Pd)
 Beard, Byron, Augusta (54-ObG)
 Beard, Donald E., Atlanta (29-U)
 Beasley, B. T., Atlanta (29- —Life)
 Beasley, Ernest W., Jr., Atlanta (29-I)
 Beason, Lewis, Butler (63-GP)
 Beck, John E., Decatur (22-I)
 Becker, W. C., Dublin (42- —Assoc)
 Bedingfield, James A., Baxley (1-GP)
 Bedingfield, W. H., Vidalia (57-GP)
 Bedingfield, W. O., Savannah (11-)
 Bedingfield, W. R., Augusta (54-OALR)
 Bedingfield, W. R., Jr., Harlem (54-I)
 Belcher, D. P., Pelham (46-GP—Assoc)
 Belcher, F. S., Monticello (38-GP—Life)
 Bell, Eugene D., Lafayette, Ind. (18- —Assoc)
 Bell, Fred M., Jr., Atlanta (29- —Assoc)
 Bell, J. A., Jr., Dublin (42-GP)
 Bell, J. E., Augusta (54-Pd)
 Bell, P. E., Sylvester (79- —Life)
 Bell, Rudolph F., Thomasville (65-U)
 Bellhouse, Helen W., Atlanta (29-PH)
 Bellville, Charles George, Bainbridge (21-S)
 Bennett, Alfred M., Atlanta (29-)
 Bennett, J. W., Augusta (54-Pd)
 Bennett, Robert L., Warm Springs (45-PM)
 Bennett, Sybil C., Valdosta (56-)
 Bennett, Truett V., Atlanta (29-ALR)
 Bennett, V. H., Gay (45-GP—Life)
 Bennett, Van B., Valdosta (56-I)
 Bennett, W. F., Buena Vista (61-GP)
 Bennett, William H., Atlanta (29-U)
 Benson, Earl B., Marietta (17-Anes)
 Benson, H. Bagley, Atlanta (29-Pd)
 Benson, Marion T., Jr., Atlanta (29-ObG)
 Benson, W. H., Jr., Marietta (17-I)
 Bent, H. F., Midville (9- —Life)
 Benton, C. C., Macon (6-Anes)
 Berg, Joseph L., Albany (23-Oph)
 Berger, Israel Reuben, Chamblee (29-R—Assoc)
 Berger, Louis, Atlanta (29-Oph)
 Berman, Dave, Columbus (47-D)
 Berman, Jerome D., Atlanta (29-Pd)
 Bern, Gerhard O., Atlanta (29- —Assoc)
 Bernard, G. T., Augusta (54-S—Life)
 Berry, Arthur N., Columbus (47-ObG)
 Berry, Maxwell R., Atlanta (29-GE)
 Berry, Robert L., Villa Rica (10-GP)
 Bickers, Donald S., Atlanta (29-NS)
 Bickerstaff, Hugh J., Columbus (47-ObG)
 Billingshurst, George A., Macon (6-GP)
 Billings, J. E., Calhoun (31-GP)
 Bird, Frank, Lake Park (56- —Life)
 Birdsong, William R., Macon (6-Pd)
 Bishop, E. L., Atlanta (29-Path)
 Bishop, Linton H., Jr., Atlanta (29-I)
 Bivings, F. Lee, Atlanta (29-Pd)
 Bivings, William Troy, Atlanta (29-S—Assoc)
 Black, Grady E., Griffin (59-Pd)
 Black, Robert J., Rome (27-Pd)
 Blackburn, J. D., Thomaston (69-Or)
 Blackford, L. Minor, Atlanta (29-I)
 Blaine, B. C., Atlanta (29-I)
 Blalock, Frank A., Rome (27-Pul)
 Blalock, John C., Atlanta (29-)
 Blalock, Tully T., Atlanta (29-I)
 Blanchard, Mercer, Columbus (47-Pd)
 Blanchard, Mercer C., Columbus (47-Pd)
 Blanchard, William, Cedartown (51-S)
 Blandford, W. C., Atlanta (29-GP)
 Bleich, J. K., Atlanta (29-I)
 Blitch, Pierce G., Jr., Augusta (54- Assoc)
 Bloom, Walter L., Atlanta (29-)
 Bloomer, William E., Decatur (22-GP)
 Blum, Leo J., Jr., Warner Robins (6-GP)
 Blumberg, Max M., Atlanta (29-I)
 Blumberg, Richard W., Atlanta (29-Pd)
 Blumenthal, Irvin, Atlanta (29-S)
 Bodziner, L. S., Savannah (11-ObG)
 Boger, Richard E., Atlanta (29-Pd)
 Bogosian, Armen, Ft. McPherson (29- —Assoc)
 Bohorfoush, J. G., Augusta (54-I)
 Boland, Charles G., Atlanta (29-ObG)
 Boland, F. Kells, Jr., Atlanta (29-S)
 Boland, J. H., Atlanta (29-Or)
 Boling, Edgar, Atlanta (29-Pr)
 Bond, D. T., Danielsville (15-GP)
 Bondurant, H. William, Atlanta (29-Or)
 Bonner, William H., Athens (15-Pd)
 Boozer, Albert Marion, Dalton (76-GP)
 Born, W. H., McRae (64-GP—Life)
 Boswell, T. C., Tate (14-GP)
 Boswell, W. C., Macon (6-Pd)
 Bosworth, E. L., Rome (27-I)
 Bosworth, Joe M., Atlanta (29-Ind)
 Boulware, John H., Atlanta (29-)
 Bowden, Ralph O., Savannah (11-S)
 Bowen, J. B., Augusta (54-S)
 Bowen, John L., Carrollton (10-Pd)
 Bowen, U. S., Los Angeles, Cal. (2-P)
 Bowles, Lester L., Augusta (54-P)
 Bowman, M. B., Albany (23-S)
 Boyd, Augustus B., Athens (15-Anes)
 Boyd, George H., Jr., Clayton (52-GP)
 Boyd, Hartwell, Atlanta (29-ObG)
 Boyd, M. L., Atlanta (29-U)
 Boyd, William S., Augusta (54-ObG)
 Boyette, L. S., Ellaville (61-GP)
 Boynton, Charles E., Atlanta (29- —Life)
 Boynton, Estelle D., Atlanta (29-N&P)
 Boyter, Henry H., Columbus (47-ObG)
 Brabson, T. H., Cornelia (33-I—Life)
 Bracher, Allen Nelson, Ft. McPherson (29- —Assoc)
 Brackett, J. Gordon, Atlanta (29-ALR)
 Bradford, H. B., Cartersville (4-GP)
 Bradford, J. E., Spring Place (76-)
 Bradford, R. W., Milledgeville (2-P)
 Bradley, D. M., Waycross (72-)
 Bradley, Paul L., Dalton (76-GP)
 Bradley, R. H., Chatsworth (76-)
 Bradshaw, Randolph G., Columbus (47-R)
 Braley, Samuel U., Dallas (17-GP)
 Bramblett, A. W., Jr., Forsyth (6-GP)
 Bramblett, Rupert H., Jr., Cumming (13-)
 Branch, W. D., Baxley (1-)
 Brandon, R. V., McDonough (59-GP)
 Brannen, Cecil N., Moultrie (19-GP)
 Brannen, Edmund A., Macon (6-ObG)
 Brannen, J. H., Valdosta (56-U)
 Brannen, O. C., Columbus (47-GP)
 Brannon, Emmett S., Rome (27-I)
 Brantley, J. G., Wrightsville (42-GP—Life)
 Brawley, William G., Decatur (22-Pd)
 Brawner, A. F., Smyrna (29-P)
 Brawner, D. L., Savannah (11-ObG)
 Brawner, James N., Atlanta (29-P—Life)
 Brawner, James N., Jr., Atlanta (29-P)
 Bregman, Larry, Atlanta (29-Pd)
 Brewer, Spencer S., Jr., Durham, N. C. (29-I—Assoc)
 Bridges, E. Cleveland, Donalsonville (21-I)
 Bridges, Glenn J., Atlanta (29-U)
 Bridges, Henry A., Bainbridge (21-GP)
 Bridges, W. L., Jr., Tifton (66-Pd)
 Brill, Harry H., Jr., Columbus (47-I)
 Brim, J. C., Pelham (46-GP)
 Brinsfield, Dorothy, Atlanta (29-Pd)
 Briscoe, C. D., Monroe (71-I)
 Britt, C. S., Brunswick (30-GP)
 Brittingham, John W., Augusta (54-I)
 Broadrick, G. L., Dalton (76-GP—Life)
 Brocato, Simone, Columbus (47-I)
 Brock, Roy Crawford, Rome (27-S)
 Brooks, Betty Ann, Decatur (22-ObG)
 Brooks, Courtney C., Blue Ridge (7-)
 Brookshire, Paul F., Jr., Kingsport, Tenn. (15-ALR)
 Brown, C. T., Guyton (11-GP)
 Brown, Charles E., Atlanta (29-I)
 Brown, F. Bert, Savannah (11-Or)
 Brown, George W., Griffin (59-R)
 Brown, H. Eugene, Emory University (29-I)
 Brown, J. B., Baxley (1-GP)
 Brown, Joseph Christopher, Conyers (48-GP)
 Brown, Lester A., Atlanta (29-ALR)
 Brown, P. F., Jr., Gainesville (34-S)
 Brown, R. G., Swainsboro (25-GP)
 Brown, Robert H., Atlanta (29-ALR)
 Brown, Robert L., Emory University (29-S)
 Brown, Roland A., Macon (6-ObG)
 Brown, S. Ross, Atlanta (29-Anes)
 Brown, Samuel Y., Atlanta (29-ObG)
 Brown, Stephen T., Atlanta (29-U)
 Brown, Stephen W., Augusta (54-R)
 Brown, Stewart D., Jr., Royston (28-GP)
 Brown, Thomas P., Thomasville (54-GP)
 Brown, Walter E., Savannah (11-GP)
 Brown, Wedford W., Athens (15-PH)
 Brust, A. A., Atlanta (29-I)
 Bryan, William W., Atlanta (29-R)
 Bryans, C. I., Jr., Augusta (54-ObG)
 Bryant, C. H., Comer (15-GP)
 Bryant, James M., Jr., Newnan (20-)
 Bryant, Milton F., Jr., Atlanta (29-S)
 Bryant, V. L., Wadley (39-)
 Buchanan, L. C., Decatur (22-S)
 Buckhaults, W. W., Savannah (11-Oph)
 Bunce, Allen H., Atlanta (29-I)
 Bundy, Eleanor E. J., Decatur (22-GP)
 Burdshaw, J. F., Augusta (54- —Assoc-Dec)
 Burdshaw, William J., Augusta (54-OALR)
 Burdick, Bingley L., Valdosta (56-GP)
 Burdine, J. M., Ellijay (7-GP)
 Burdine, Winston E., Atlanta (29-P)
 Burdison, William R., Augusta (54- —Assoc)
 Burford, Robert S., Brunswick (30-GP)
 Burgamy, Clyde A., Augusta (54-)
 Burge, Dan, Atlanta (29-I)

Burgess, Taylor S., Atlanta (29-ALR)
 Burke, B. Russell, Atlanta (29-ALR)
 Burleigh, Bruce D., Marietta (17-GP)
 Burnett, Stacy W., Atlanta (29-Pd)
 Burns, D. L., Valdosta (56-GP)
 Burns, J. K., Gainesville (34-S)
 Burns, John Knox, III, Gainesville (34-
 —Assoc)
 Burns, Lloyd L., Atlanta (29- —Assoc)
 Burns, R. A., Blue Ridge (7-GP)
 Burrell, Zeb, Jr., Milledgeville (2-I)
 Burson, E. Napier, Jr., Atlanta (29-I)
 Burton, Herbert W., Atlanta (29-I)
 Busbee, Perry G., Cordele (26-GP)
 Busch, John F., Marietta (17-PH)
 Busey, T. J., Fayetteville (16-GP)
 Bush, Albert R., Dublin (42-I)
 Bush, James L., Douglas (18-OALR)
 Bush, John, Columbus (47-GP)
 Bush, O. B., Atlanta (29-)
 Bush, Walter H., Macon (6-I)
 Russell, B. R., Waycross (72-GP)
 Russell, J. A., Rochelle (77- —Life)
 Bussey, J. G., Austell (17-S)
 Butler, Clarence, Columbus (47-I)
 Butler, E. E., Gainesville (34- —Assoc-
 Dec)
 Butterfield, Donald L., Dalton (76-PH—
 Dec)
 Byers, Kathleen, Atlanta (29-Anes—
 Assoc)
 Byne, J. M., Jr., Waynesboro (9-I)
 Byram, James H., Atlanta (29-ObG)
 Byrd, Edwin S., Atlanta (29-)
 Byrd, H. G., Athens (15-Ob)
 Byrd, T. Luther, Atlanta (29-I)
 Byrd, William McCulloh, Atlanta (29-
 —Assoc)

C

Cacchioli, Louis G., Hartwell (35-)
 Cain, E. J., Columbus (47-U)
 Cain, James R., Atlanta (29-Path)
 Cain, Robert Thomas, Clayton (52-GP)
 Cain, Sylvester, Norcross (13-GP)
 Cale, Ellsworth F., Atlanta (29-Pd)
 Calhoun, F. P., Jr., Atlanta (29-Oph)
 Calhoun, F. Phinzy, Atlanta (29-Oph—
 Life)
 Calhoun, W. C., Waycross (72-Ob)
 Calk, Guy L., Atlanta (29-ObG)
 Callaway, E. J., LaGrange (48-GP)
 Callaway, Enoch, LaGrange (68-S)
 Camp, R. Thornton, Fairburn (29-GP)
 Campbell, Harold Eugene, Milledgeville
 (2-GP)
 Campbell, John D., Atlanta (29-P)
 Campbell, Leonard H., Macon (6-Path)
 Campbell, Richard P., Cedartown (51-)
 Campbell, William E., Jr., Atlanta (29-
 Oph)
 Candler, Marguerite L., Atlanta (29-I)
 Candler, Robert W., Atlanta (29-S)
 Cantrell, J. E., Albany (23-GP)
 Capo, James P., Rome (27-Pul)
 Cargill, Walter H., Brookhaven (29- —
 Assoc)
 Carnes, William C., Elberton (24-)
 Carpenter, Frederick A., Emory Univer-
 sity (29-Anes—Assoc)
 Carson, Harold B., Chatsworth (76-)
 Carson, James Maxwell, Atlanta (29-
 —Assoc)
 Carson, W. P., Chatsworth (76-)
 Carswell, Augustin S., Augusta (54-Or)
 Carswell, Harold A., Oakland, Calif.
 (54- —Assoc)
 Carswell, John H., Hiwassee (33-GP)
 Carter, A. W., Jr., Forest Park (29-GP)
 Carter, Curtis H., Augusta (54-I)
 Carter, Harvey R., Augusta (54- —
 Assoc)
 Carter, Henry G., Jr., Decatur (22-GP)

Carter, J. G., Scott (42-GP—Life)
 Carter, Sandy B., Atlanta (29-I)
 Carter, Yancey F., Jr., Ashburn (26-GP)
 Cary, H. R., Milledgeville (2-GP)
 Cary, R. Frank, Macon (6-PH)
 Cason, H. B., Warrenton (73-GP)
 Cason, William M., Atlanta (29-OALR)
 Cathcart, Don F., Atlanta (29-Pd)
 Cato, Robert E., Macon (6-R)
 Caton, William L., Atlanta (29-ObG)
 Cauble, George, Acworth (17-)
 Center, A. H., Savannah (11-PN)
 Chaffin, E. F., Toccoa (60-)
 Chalmers, Rives, Atlanta (29-P)
 Chambers, Benjamin M., Atlanta (29-
 Oph)
 Chambers, James W., LaGrange (68-I)
 Chambers, William R., Atlanta (29-NS)
 Chambless, Miriam Walker, Hamilton
 (45-GP)
 Chambless, William G., Hamilton (45-
 GP)
 Champion, W. L., Atlanta (29-U—Life-
 Dec)
 Chandler, A. Bleakley, Augusta (54-)
 Chandler, C. B., Brunswick (30-Oph)
 Chandler, D. B., Lula (34-GP—Life)
 Chandler, John L., Augusta (54-Or)
 Chaney, Ralph H., Augusta (54-S)
 Chappell, Amey, Atlanta (29-I)
 Chastain, J. B., Columbus (47-Pd)
 Chastain, J. R., Buford (13-)
 Chaudron, P. O., Cedartown (51-S—
 Life)
 Cheek, O. H., Dublin (42-PH—Life)
 Chelton, L. Guy, Atlanta (29-I)
 Cheney, Fred D., Dublin (42-I—Assoc)
 Cheshire, Howard L., Thomasville (65-
 ObG)
 Cheves, H. L., Jr., Union Point (78-GP)
 Cheves, Harry L., Union Point (78-GP)
 Cheves, L. C., Jr., Montezuma (61-GP)
 Childs, J. R., Atlanta (29-OALR)
 Chiles, N. Hampton, Atlanta (29-I)
 Chipman, R. A., Columbus (47-S)
 Chisholm, J. F., Savannah (11-OALR)
 Chrisman, W. W., Macon (6-)
 Christmas, Joseph T., Vienna (26-GP)
 Christopher, F. E., Atlanta (29-GP)
 Cibelli, Louis A., Atlanta (29- —Assoc)
 Cirincione, V. J., Savannah (11-D)
 Claiborne, T. Sterling, Atlanta (29-I)
 Clark, F. B., Austell (17-GP)
 Clark, James J., Atlanta (29-R)
 Clark, Remer Y., Jr., Marietta (17-GP)
 Clark, Robert A., Jr., Macon (6-NS)
 Clark, Spurgeon William, Jr., Atlanta
 (29-Oph—Assoc)
 Clark, T. H., Douglas (18- —Assoc)
 Clark, W. H., LaGrange (68-S—Life-
 Dec)
 Clarke, M. L. B., Atlanta (29-GP)
 Clary, Thomas L., Jr., Augusta (54-I)
 Clary, W. Upton, Savannah (11-NS)
 Claxton, E. B., Dublin (42- —Life)
 Clay, Calder B., Jr., Macon (6-S)
 Clay, J. Emory, Macon (6-GP)
 Cleckley, Hervey M., Augusta (54-P)
 Clements, Fred N., Adel (56-GP)
 Clements, J. L., Jr., Atlanta (29-R)
 Cleveland, Parish B., Toccoa (60-Anes)
 Clifford, William S., Columbus (47-
 ObG)
 Clifton, Ben H., Atlanta (29-S)
 Cline, Peter J., Atlanta (29-I)
 Cline, Steven G., Atlanta (29-G)
 Clodfelter, T. C., Milledgeville (2-P—
 Life)
 Clonts, W. T., Marietta (17-GP)
 Clouse, John E., Jr., Griffin (59-GP)
 Cobb, Claud P., Jr., East Point (29-GP)
 Cochran, T. A., Ringgold (70-GP)

Coe, H. M., Brunswick (30-Or)
 Cofer, Olin S., Atlanta (29-G)
 Cogdell, B. H., Nicholls (18-)
 Cohen, I. R., Atlanta (29-Pd)
 Coker, Grady N., Canton (14-S)
 Cole, Allan A., Macon (6-I)
 Cole, G. C., Dallas (29- —Assoc)
 Cole, W. A., Savannah (11-R—Life)
 Coleman, Fred J., Dublin (42-S)
 Coleman, Otha K., Cordele (26-)
 Coleman, Reese C., Jr., Atlanta (29-U)
 Coleman, W. E., Hawkinsville (50-GP)
 Coles, W. C., Atlanta (29-R)
 Collier, Fred C., Boston, Mass. (29-
 —Assoc)
 Collier, Thomas W., Brunswick (30- —
 Assoc)
 Collings, Thomas A., Atlanta (29- —
 Assoc)
 Collins, Braswell E., Macon (6-OALR)
 Collins, J. C., Collins (62-GP)
 Collins, J. J., Thomasville (65-R)
 Collinsworth, Allen M., Atlanta (29-Ind)
 Collinsworth, Pleasant L., Atlanta (29-
 Ind)
 Colquitt, Alfred O., Jr., Marietta (17-
 ObG)
 Colson, A. C., Glennville (62-GP—Life)
 Colvin, E. D., Atlanta (29-Ob)
 Colvin, Ernest S., Atlanta (29-OALR)
 Combs, J. A., Decatur (29-GP—Life)
 Combs, James M., Atlanta (29-GP)
 Combs, Joe D., Atlanta (29-P)
 Compton, William S., Atlanta (29-S—
 Assoc)
 Comstock, George W., Columbus (47-
 Pul)
 Conger, A. B., Columbus (47-S)
 Conger, P. D., Moultrie (19-GP)
 Conn, Lee R. M., Columbus (47-S)
 Conner, D. H., Eastman (50-)
 Conner, George R., Columbus (47-S)
 Conner, H. I., Vidalia (57-S)
 Cook, E. R., III, Savannah (11-I)
 Cook, W. C., Columbus (47-Pd)
 Cook, W. S., Albany (23-GP—Life)
 Cooke, Virgil C., Savannah (29-GP—
 Life)
 Cooke, Waverly L., Columbus (47-ObG
 —Life)
 Cooley, J. B., Atlanta (22-)
 Coolidge, C. W., Atlanta (29-ObG)
 Cooper, Charles F., Jr., Atlanta (29-
 Oph)
 Cooper, Frederick W., Jr., Emory Uni-
 versity (29-S)
 Cooper, Gerald R., Atlanta (29-I—
 Assoc)
 Cooper, M. N., Atlanta (29-I)
 Copeland, H. J., Griffin (59-ObG)
 Copeloff, M. B., Atlanta (29-GP)
 Coppedge, W. W., East Point (29-ObG)
 Corbitt, Melvis O., Augusta (54-Ob)
 Corley, Frank L., Atlanta (29-GP—Life)
 Corn, Ernest (Macon (6-U)
 Cornett, Murl, Lafayette (70-GP)
 Cornwell, G. K., Fitzgerald (5-GP)
 Corpe, R. F., Rome (27-S)
 Corry, J. A., Barnesville (41-I—Life-
 Dec)
 Cousins, W. L., Atlanta (29-I)
 Cowan, Z. S., Clearwater, Fla. (29-GP—
 Assoc)
 Coward, Allen W., Savannah (11-)
 Cowart, Charles T., LaGrange (68-S)
 Cowart, G. Thomas, Atlanta (29-U)
 Cox, Joel E., Griffin (59-GP)
 Coyle, J. A., Dublin (42- —Assoc)
 Cranston, W. J., Augusta (54-I—Life)
 Crawford, Clyde L., Atlanta (29-S)
 Crawford, H. C., Atlanta (29-OALR)
 Crawford, John B., Barnesville (41-GP)

Crawford, W. B., Savannah (11-S—Life)
 Crawford, W. B., Jr., Savannah (11-)
 Crawley, Walter G., Marietta (17-Pd)
 Crenshaw, Fred, Rome (27-Pul)
 Crichton, Robert B., Augusta (54-)
 Crider, Harry J., Jr., Atlanta (29-ObG)
 Crispell, Raymond S., Atlanta (29- — Assoc)
 Crone, R. D., Athens (15-Or)
 Crosby, William V., Athens (15-ObG)
 Cross, John B., Emory University (29-ObG)
 Cravatt, J. G., Camilla (46-GP)
 Crow, H. E., Rome (27-Pul)
 Crowdis, James Hudson, Jr., Blakely (58-)
 Crowe, Norman J., Sylvester (79-GP)
 Crowe, William R., Atlanta (29-I)
 Cruise, Joe S., Atlanta (29-Pul)
 Crumbly, A. J., Atlanta (29-S)
 Crutcher, James Carroll, Brookhaven (29- — Assoc)
 Culbreth, Ernest W., Lindale (27-)
 Cunningham, C. E., Decatur (22-GP)
 Curtis, Walker L., College Park (29-I)
 Curtiss, Edgar J., Columbus (47- — Assoc)

D

Dabney, W. C., Ocean Springs, Miss. (29- —Life)
 Dallas, R. E., Thomaston (69-GP)
 Daly, Leo P., Atlanta (29-S)
 Dancy, William R., Savannah (11-GE—Life)
 Daniel, A. B., Statesboro (8-S)
 Daniel, Ernest F., Jr., Augusta (54- — Assoc)
 Daniel, Frank C., Pavo (65-S)
 Daniel, J. W., Claxton (8-GP—Life)
 Daniel, J. W., Jr., Macon (6-GP)
 Daniel, John W., Jr., Savannah (11-GP)
 Daniel, William W., Atlanta (29-ObG)
 Daniels, Charles W., Atlanta (29-ObG)
 Darby, V. L., Vidalia (57-S)
 Dashiell, Waverly B., Columbus (47-ObG)
 Davenport, Lowrey F., Macon (6-I)
 Davenport, T. F., Atlanta (29-Pd)
 Daves, V. C., Vienna (26-GP)
 Davidson, Charles Warren, Emory University (29- — Assoc)
 Davidson, John K., III, Columbus (47-I)
 Davis, A. W., Warrenton (73-GP)
 Davis, Abe J., Augusta (54-PH)
 Davis, B. B., Gainesville (34-Pd)
 Davis, Byron C., Valdosta (56-Path)
 Davis, Charles L., Atlanta (29-S)
 Davis, E. B., Byromville (26-GP)
 Davis, Eschol E., Meigs (65-GP)
 Davis, Feltz C., Gray (6-ALR)
 Davis, Floyd E., Waycross (72-GP)
 Davis, Guy C., Atlanta (29-S)
 Davis, H. G., Jr., Sylvester (79-GP)
 Davis, J. E., Atlanta (29-GP—Life)
 Davis, J. M., Dublin (42- — Assoc)
 Davis, M. Bedford, Jr., Atlanta (29-S)
 Davis, Ralph J., Rome (27-S)
 Davis, Robert C., Atlanta (29-)
 Davis, Shelley C., Atlanta (29-S)
 Davis, Thomas Ned, Irwinton (6-GP)
 Davis, W. A., Macon (6-Pul)
 Davis, William B., College Park (29-Pd)
 Davison, Hal M., Atlanta (29-I)
 Dawson, Harry, Shannon (27-)
 Deal, Albert M., Statesboro (8-S)
 Deal, Helen R., Statesboro (8-Pd)
 Deal, John D., Portal (8-)
 Dean, Harry B., Norristown, Pa. (26-)
 Deaton, J. H., Columbus (47-R)
 DeCaradeuc, St. J. R., Savannah (11-OALR—Life)
 Defreese, Samuel, Monroe (71-GP)

DeJarnette, R. H., Vidalia (57-)
 Dellinger, Raiden W., Rome (27-S)
 Deloach, A. W., Waycross (72-S)
 Demmond, E. C., Savannah (11-ObG)
 Denham, Helen M., Ft. Jackson (29-)
 Denmark, L. D., Atlanta (29-Pd)
 Denney, Roy L., Carrollton (10-OALR)
 Dennison, David B., Atlanta (29-I)
 DeReamer, John W., Savannah (11-D)
 Derrick, H. C., Oglethorpe (36- —Life)
 Derrick, Howard C., Jr., Lafayette (70-GP)
 DeVaughn, N. M., Augusta (54-I)
 Dew, J. Harris, Atlanta (29-S)
 Dickens, C. H., Madison (49-Pd)
 Dickey, L. E., Jr., Macon (6-)
 Dickson, Roger W., Atlanta (29-Pd)
 Dietrich, Paul H., Chattanooga, Tenn. (70-)
 Dillard, George P., Augusta (17-GP)
 Dillard, Guy J., Columbus (47-I)
 Dillard, James Bascom, Davisboro (74-GP—Assoc)
 Dillard, William B., Jr., Cartersville (4-GP)
 Dillinger, George R., Thomasville (65-I)
 Dimmock, A. M., Atlanta (29-I)
 Dismuke, H. L., Ocilla (5-S)
 Dismuke, James C., Adel (56-GP)
 Dixon, Ellis H., Jr., Augusta (54-ObG—Assoc)
 Dixon, P. K., Gainesville (34-S)
 Dobes, W. L., Atlanta (29-D)
 Dobson, J. L., Atlanta (29-GP)
 Dodd, William Asa, Wrightsville (42-GP)
 Dodelin, R. A., Durham, N. C. (29- — Assoc)
 Dorough, W. S., Atlanta (29-)
 Dougherty, Mark S., Jr., Atlanta (29-I)
 Dove, W. B., Macon (6- —Life)
 Dover, J. C., Clayton (52-GP)
 Dover, Tom A., Athens (15-Ob)
 Dowda, F. W., Atlanta (29-I)
 Dowling, George B., Atlanta (29-I—Assoc)
 Dowman, Charles E., Atlanta (29-NS)
 Dowman, Cordelia K., Atlanta (29-Pd)
 Downey, W. P., Tallapoosa (10-GP)
 Doyle, J. P., Camilla (46-GP)
 Doyle, Joseph T., Albany, N. Y. (29- —Assoc)
 Drake, Charles H., Glennville (62-GP)
 Drane, Robert, Savannah (11-R)
 DuBose, Bolling S., Jr., Athens (15-I)
 Duggan, A. Dan, Washington (78-GP)
 Duke, Tom W., New Haven, Conn. (29- —Assoc)
 Duley, Jack R., Nicholls (18-)
 Dunbar, Ernest A., Jr., Forest Park (29-Pd)
 Dunbar, Walter S., Atlanta (29-I)
 Duncan, G. A., Decatur (22-GP)
 Duncan, J. Harry, Savannah (11-Oph)
 Duncan, John A., Martinez (54-)
 Duncan, John B., Atlanta (29-ObG)
 Dunlap, Ernest B., Jr., Atlanta (29-Or)
 Dunn, Laurence B., Savannah (11-GP)
 Dunn, Robert G., Jr., Albany (23-R)
 Dunstan, Edgar M., Atlanta (29-I)
 Dupree, G. W., Gordon (6-GP)
 Dupree, J. T., Macon (6-S)
 Dupree, Thomas E., Bainbridge (21-GP)
 Durden, John G., Jr., Columbus (47-S)
 Durden, W. Faust, Gainesville (34-S)
 Durham, Bon M., Americus (61-I)
 Durham, W. P., Abbeville (50-OALR)
 Duvall, W. B., Atlanta (29-Pr)
 Dyer, C. W., Macon (6-ObG)
 Dykes, A. N., Columbus (47-S)

E

Earl, H. L., Sparta (49-Pd—Assoc)

Earle, Walter C., N. Atlanta (29-PH)
 Easley, Curran S., Jr., LaGrange (68-P)
 Eberhardt, Reese C., Macon (6-GP)
 Eberhart, Charles, Atlanta (29-U)
 Echols, George L., Milledgeville (2-P—Life)
 Echols, Joseph M., Augusta (54-ObG)
 Edenfield, R. W., Macon (6-S)
 Edge, H. M., Blairsville (7-GP)
 Edge, J. H., Atlanta (60- —Life)
 Edgerton, M. T., Atlanta (29-OALR)
 Edmondson, T. L., Tifton (66-GP)
 Edwards, Ernest G., Savannah (11-Or)
 Edwards, Frances K., Decatur (22-Pd)
 Edwards, Franklin D., Columbus (47-U)
 Edwards, William T., Jr., Atlanta (29-Oph)
 Egan, M. J., Savannah (11-S)
 Ehrlich, M. A., Bainbridge (21-Pd)
 Elder, Ivan R., Columbus (47-GP)
 Elder, John D., Athens (15-ObG)
 Eldridge, F. G., Valdosta (56-R)
 Elkin, Dan C., Lancaster, Ky. (29-S—Hon)
 Elkins, James A., Columbus (47-Or)
 Elliott, C. B., Cedartown (51-S)
 Elliott, Clifford C., Sargent (20-I)
 Elliott, J. L., Savannah (11-I)
 Elliott, W. G., Cuthbert (53-GP)
 Ellis, H. C., McDonough (59-GP)
 Ellis, John Oliver, Atlanta (29-R)
 Ellis, William P., Chipley (45-GP—Life)
 Ellison, Robert G., Augusta (54-S)
 Elmer, R. A., Atlanta (29-R)
 Engel, M. F., Darien (30-)
 Engler, Harold S., Augusta (54-S)
 English, R. E. L., Griffin (59-GP—Life)
 Epps, George L., Columbus (47-R)
 Epting, M. J., Savannah (11-S)
 Equen, Murdock, Atlanta (29-ALR)
 Erwin, Goodloe Y., Athens (15-I)
 Erwin, H. L., Dalton (76- —Life)
 Eskridge, Frank, Atlanta (29-S)
 Eskridge, Frank L., Jr., Atlanta (29-)
 Estes, H. G., Atlanta (29-)
 Etheridge, E. H., Washington, D. C. (37-GP)
 Evans, Albert L., Atlanta (29-S)
 Evans, Arthur R., Jr., Forest Park (29-GP)
 Evans, E. C., Atlanta (29-I)
 Evans, E. L., Tifton (66-GP)
 Evans, Harry C., Newington (55-)
 Evans, J. Rufus, Stone Mountain (22-GP)
 Evans, James P., Augusta (54- — Assoc)
 Everett, Theodore, Augusta (54-U)
 Everhart, Guy, Loganville (71-)
 Ewing, R. B., Macon (6-D)
 Ezzard, Thomas M., Roswell (29-GP—Life)
 Ezzard, W. P., Lawrenceville (13-I)

F

Fackler, William B., Jr., LaGrange (68-I)
 Faggart, G. H., Savannah (11-OALR)
 Fancher, James K., Atlanta (29-I)
 Fanning, O. O., Atlanta (29- —Life-Dec)
 Farmer, C. Hall, Macon (6-Pd)
 Farmer, Charles W., Jr., Newnan (20-OALR)
 Farris, John Duncan, Atlanta (29-ObG—Assoc)
 Farris, John J., Wadley (39-)
 Faulkner, Alva A., Augusta (54-ObG)
 Faulkner, John A., Augusta (54-Or)
 Fedack, W. J., East Point (29-GP)
 Feild, W. M., Albany (23-)
 Felber, Ernest, Atlanta (29-U)
 Felder, Louis, McDonough (59-I)
 Felder, Richard E., Atlanta (29-P)
 Fenn, Henry R., Americus (61-GP)

Ferguson, I. A., Atlanta (29-S)
 Fernan-Nunez M., Dublin (42-Path—Assoc)
 Ferrell, R. G., Jr., Macon (6-S)
 Ferrell, T. J., Waycross (72-S)
 Ferrence, John A., Whigham (32-)
 Ferris, Eugene B., Atlanta (29-I)
 Ferris, Harold A., Atlanta (29-I)
 Fike, Rupert Howard, Moultrie (19-)
 Fillingim, David B., Savannah (11-GP)
 Finch, Henry M., Atlanta (29-Pr)
 Fincher, Edgar F., Emory University (29-NS)
 Findley, C. W., Vidalia (57-ALR)
 Findley, Thomas, Augusta (54-I)
 Fish, John S., Atlanta (29-Ob)
 Fisher, George B., Franklin (68-)
 Fisher, William R., Atlanta (29-ALR)
 Fitts, John B., Atlanta (29- —Life)
 Fitzhugh, F. W., Jr., Atlanta (29-I)
 Fitzhugh, S. A., Griffin (59-Pd)
 Flanagan, W. M., Waycross (72-)
 Flanagan, W. Stewart, Augusta (54-P1)
 Fleming, C. A., Tifton (66-)
 Fleming, P. N., Savannah (11-OALR)
 Flesch, W. L., Waycross (72-U)
 Fletcher, H. Quigg, Jr., Columbus (47-S)
 Flinchum, Darius, Atlanta (29-Or)
 Florence, Loree, Athens (15-Pd)
 Florence, Tom, Atlanta (29-U)
 Flowers, Eugene Monroe, Tifton (66-GP)
 Floyd, Charles S., Loganville (71-GP)
 Floyd, Earl H., Atlanta (29-U)
 Floyd, T. J., Jr., Griffin (59-S)
 Floyd, W. E., Statesboro (8-S)
 Flynn, Gregory E., Atlanta (29-Oph)
 Flynn, James T., Jr., Moultrie (19-OALR)
 Fokes, Robert E., Jr., Moultrie (19-OALR)
 Fonseca, J. E., Dublin (42- —Assoc)
 Forbes, George Lester, Jr., Atlanta (29-Path)
 Forester, B. W., Macon (6-I)
 Forrer, D. A., Griffin (59-OALR—Life)
 Foster, Gurdon R., Jr., McDonough (39-GP)
 Foster, Kimsey E., College Park (29-GP—Life)
 Foster, Maude E., Atlanta (29- —Life)
 Fountain, T. Gray, Albany (23-S)
 Fowler, A. H., Marietta (17-GP)
 Fowler, C. Dixon, Atlanta (29-Pd)
 Fowler, C. H., Jr., Decatur (22-I)
 Fowler, Major F., Atlanta (29-U)
 Fowler, Mark W., Albany (23-)
 Fowler, R. W., Marietta (17-Pd)
 Fox, Brent, Columbus (47-OALR)
 Fox, Vernelle, Atlanta (29-I)
 Frayser, W. N., Macon (6-GP)
 Frech, H. C., Savannah (11-ObG)
 Free, Jack Rawlings, Atlanta (29- —Assoc)
 Freedman, L. M., Savannah (11-S)
 Freedman, Milton H., Atlanta (29-I)
 Freeman, James C., Sylvania (55-GP)
 Freeman, Thomas N., LaGrange (68-GP)
 Freeman, Thomas R., Savannah (11-S)
 Friedewald, William F., Atlanta (29-I)
 Friedman, Charles, Augusta (54-Or)
 Frierson, Norton W., Jr., Atlanta (29-GP)
 Fristoe, John W., Jr., Atlanta (29-ObG)
 Frost, H. R., Swainsboro (25-GP)
 Fry, Elmer L., Macon (6-Anes)
 Frye, Augustus H., Jr., Griffin (59-S)
 Fulghum, C. B., Milledgeville (2-I)
 Fulghum, Thomas E., Augusta (54-GALR)
 Fuller, George W., Atlanta (29-S)
 Fuller, William A., Augusta (54-I)

Fulmer, William H., Savannah (11-GP)
 Funderburke, A. G., Moultrie (19-GP)
 Funk, F. James, Jr., Atlanta (29-Or)
 Funke, John, Atlanta (29-Or)
 Funkhouser, W. L., Atlanta (29-Pd—Life)
 Fussell, J. K., Rhine (64-I)

G

Gabler, Regina, Atlanta (29-ObG)
 Gafford, A. V., Rome (27-OALR)
 Galambos, John T., Atlanta (29-I—Assoc)
 Galin, A. N., Brunswick (30-GP)
 Gallaher, B. Shannon, N. Augusta, S. C. (54-I)
 Gallemore, J. L., Perry (6-GP)
 Gallis, Anthony H., Athens (15-I)
 Galloway, William H., Atlanta (29-ObG)
 Galvin, William H., Emory University (29-Anes)
 Gambrell, W. Elizabeth, Atlanta (29-I)
 Gammon, William Roderick, Atlanta (29- —Assoc)
 Gardner, J. L., Sulphur Springs (70- —Dec)
 Garland, Charles M., Jr., Smyrna (17-ObG)
 Garner, J. E., Thomaston (69-GP)
 Garner, J. S., Jr., Rome (27-)
 Garner, John P., Atlanta (29-GP)
 Garner, W. R., Gainesville (34-I)
 Garrard, J. L., Rome (27- —Life)
 Garrett, Luke G., Jr., Austell (17-)
 Garrison, D. H., Clarkesville (33-GP)
 Garrison, Fletcher O., Demorest (33-GP)
 Garrison, Joseph Mayes, Thomson (44-GP)
 Gatewood, T. Schley, Americus (61-ObG)
 Gay, Brit B., Jr., Emory University (29-R)
 Gay, Frank M., Moultrie (19-GP)
 Gay, Thomas Bolling, Atlanta (29-Pd)
 Germain, A. H., Atlanta (29-GP)
 Gershon, Nathan I., Atlanta (29-OALR)
 Ghent, Oliver T., Gainesville (34-R)
 Gholson, A. R., Atlanta (29-Anes)
 Gibbs, R. I., Jr., Decatur (22-I)
 Gibson, F. N., Thomson (44-GP)
 Gibson, Frank L., Bainbridge (21-S)
 Gibson, I. Malcolm, Valdosta (56-I)
 Gibson, John S., Atlanta (29- —Assoc)
 Gibson, Roy L., Columbus (47-ObG)
 Gibson, Sam T., Washington 13, D. C. (29- —Assoc)
 Gibson, Wallace M., Milledgeville (2-)
 Giddens, C. C., Valdosta (56-GP)
 Giddens, I. S., Lakeland (56-GP)
 Giddings, C. Glenville, Atlanta (29-I)
 Giddings, Glenville A., Atlanta (29-I)
 Gilbert, Ben P., Gainesville (34-Pd)
 Gilbert, R. B., Greenville (45-GP—Life-Dec)
 Gilbert, Warren, Rome (27-GP)
 Gillespie, Robert H., Atlanta (29-ObG)
 Gillette, Harriet E., Atlanta (29-PM)
 Gilliam, O. D., Columbus (47-S)
 Ginder, David Richards, Emory University (29- —Assoc)
 Girardeau, Joseph L., Camp Carson, Colo. (29-ObG—Assoc)
 Gish, George R., Jr., Emory University (29-NS)
 Gist, William T., Summerville (12-GP)
 Glass, Lamar F., Atlanta (29-S)
 Gleaton, E. N., Savannah (11-Pd)
 Glenn, Wadley R., Atlanta (29-S)
 Glisson, C. Stedman, Jr., Atlanta (29-ObG)
 Glover, D. H. G., Jesup (75-PH)
 Glover, Howard C., Jr., Newnan (20-Pd)
 Glover, N. B., Newnan (20-Pd)

Glover, O. G., Jr., Canton (14-ObG—Assoc)
 Gober, W. Mayes, Marietta (17-Ob)
 Gold, Perry, Atlanta (29-Pd)
 Goldberg, Ira, Augusta (54-ObG)
 Golden, Abner, Emory University (29-Path)
 Goldenstar, G. W., Savannah (11-Oph)
 Goldin, Harold W., Rockmart (51-GP)
 Goldin, Robert B., Rockmart (51-GP)
 Goldman, Benjamin, Hazlehurst (72-GP)
 Goldsmith, Lauren H., Athens (15-Pd)
 Goldstein, Josef J., Warner Robins (6-)
 Goldwasser, Fred E., Alma (72-GP)
 Golsan, Willard R., Macon (6-U)
 Good, John W., Cedartown (51 —Life)
 Good, W. H., Jr., Toccoa (60-S)
 Goodman, Leon B., Macon (6-ObG)
 Goodpasture, W. C., Atlanta (29-GP)
 Goodwin, F. H., Atlanta (29-I)
 Goodwin, H. A., Jr., Summerville (12-GP)
 Goodwin, T. W., Augusta (54-S)
 Goodwyn, Thomas P., Atlanta (29-Or)
 Goodyear, William E., Atlanta (29-U)
 Goolsby, R. C., Jr., Macon (6-Pd)
 Goss, Christopher C., Ashburn (26-GP)
 Goss, Woodrow, Ashburn (26-)
 Gottschalk, Robert Bruce, Savannah (11-S)
 Gower, Orien T., Jr., Cordele (26-GP)
 Gower, W. J., Thomaston (69-GP)
 Grace, Kenneth D., LaGrange (68-S)
 Grady, Edgar Dunkley, Chamblee (29- —Assoc)
 Grady, Henry Wiley, LaGrange (68-R)
 Graffagnino, P. C., Columbus (47-ObG)
 Graham, Rufus E., Savannah (11-GP—Life)
 Grant, James D., Augusta (54-I)
 Graves, Richard F., Winder (37-GP)
 Gray, Arthur R., Atlanta (29-S—Assoc)
 Gray, J. D., Augusta (54-I)
 Graydon, E. Leonard, Atlanta (29-GP)
 Green, Charles G., Waynesboro (9-GP)
 Green, Donarell R., Jr., Athens (15-GP—Sci)
 Green, Edmond W., Hapeville (29-GP)
 Green, George F., Sparta (49-GP)
 Green, James A., Athens (15-S)
 Green, Margaret L., Atlanta (29-Pd)
 Greenberg, Irving L., Atlanta (29-S)
 Greenblatt, Robert B., Augusta (54-ObG)
 Greene, Marvin L., Monticello (38-GP)
 Greer, C. B., Brunswick (30-Ind)
 Greer, Zack E., Macon (6-PH)
 Gregory, Hugh H., Atlanta (29-S)
 Gremmel, Warren W., Atlanta (29-GP)
 Griffin, Claude, Atlanta (29-OALR)
 Griffin, Edwin M., Bainbridge (21-GP)
 Griffin, Eugene L., Atlanta (29-ObG)
 Griffin, L. H., Claxton (8-GP)
 Griffith, Joseph E., Marietta (29-Ind)
 Griggs, H. E., Conyers (48-)
 Grimes, W. H., Jr., Atlanta (29-Cb)
 Gross, O. S., Vidalia (57-GP)
 Grove, Lon W., Atlanta (29- —Assoc)
 Grubbs, J. H., Molena (69- —Life)
 Gucker, Thomas, III, Bryn Mawr, Pa (45-Or)
 Gude, A. V., Atlanta (29-Anes)
 Guiffin, Thomas N., Atlanta (29-S)
 Guilfoil, Paul H., West Port, Conn. (29-S—Assoc)
 Gustin, R. M., Athens (15-GP)
 Guy, J. Candler, Atlanta (29-U)

H

Hackett, Laurier E., Camilla (46-GP)
 Hackett, Walter G., Rome (27-S)
 Hackney, J. F., Atlanta (29-PH)
 Hagan, J. H., Rockmart (51-GP)

Hagans, James A., Oklahoma City, Okla. (29-)
Hagood, G. F., Marietta (17-GP)
Hagood, M. M., Marietta (17-S)
Hailey, Howard, Atlanta (29-D)
Hailey, Hugh, Atlanta (29-D)
Hair, Lawton Quinby, Augusta (54-I)
Hall, Charles E., Jr., Atlanta (29-Pr)
Hall, David P., Nashville, Tenn. (70-S)
Hall, John L., Macon (6-Or)
Hall, Maxwell F., Jr., Emory University 29- —Assoc)
Hall, Thomas H., Macon (6-Oph—Life)
Hall, Thomas M., II, Macon (6-P)
Hall, W. D., Calhoun (31-S)
Hallman, B. L., Atlanta (29-I)
Hallum, Alton V., Atlanta (29-Oph)
Ham, Oscar Emerson, Savannah (11-Pd)
Hames, Curtis G., Claxton (8-)
Hamff, Leonard H., Atlanta (29-I)
Hamilton, R. E., Douglasville (10-)
Hamilton, Thomas E., Marietta (10-Ind)
Hamilton, Walton W., Augusta (54-R—Assoc)
Hamilton, William F., Jr., Augusta (54-R)
Hamm, William G., Atlanta (29-PL)
Hammett, H. H., LaGrange (68-GP)
Hammett, H. H., Jr., LaGrange (68-OALR)
Hammond, G. W., Newnan (20-GP)
Hammond, R. L., Jackson (59-GP)
Hanberry, Richard L., Jr., Macon (6-ObG)
Hancock, Robert K., Atlanta (29-ObG)
Hancock, S. L., Cairo (32-)
Hand, Hollis, LaGrange (68-S)
Hanes, O. Eugene, Atlanta (29-I)
Hankey, Daniel D., Atlanta (29-I)
Hanner, James P., Atlanta (29-Pd)
Hanson, J. Fletcher, Macon (6-I)
Harbin, Lester, Rome (27-S)
Harbin, R. M., Jr., Rome (27-S)
Harbin, Thomas S., Rome (27-OALR)
Harbin, William P., Jr., Rome (27-I)
Hardeman, Frank, Jr., Savannah (11-GP)
Harden, W. E., Waycross (72-GP)
Hardman, Billy S., Gainesville (34-ObG)
Harmer, A. A., Bonita Springs, Fla. (70- —Assoc)
Harp, S. L., Toccoa (60-GP)
Harper, A., Wray (5- —Life)
Harper, Byron F., Jr., Atlanta (29-I)
Harper, Fred M., Jesup (75-GP)
Harper, G. T., Dewy Rose (35- —Life)
Harper, Harry T., Jr., Augusta (54-I)
Harper, Sage, Douglas (18-GP)
Harrell, H. P., Augusta (54-Pd)
Harris, C. A., The Rock (69-)
Harris, E. R., Winder (37-)
Harris, H. B., Athens (15-G)
Harris, J. Frank, Atlanta (29-I)
Harris, T. A., Atlanta (29-ObG)
Harris, Wesley W., Royston (28-GP)
Harrison, F. N., Augusta (54-ObG)
Harrison, James H., Ft. Crowder, Mo. 29- —Assoc)
Harrison, W. B., Athens (15-PH—Life)
Harriss, E. R., Winder (37-)
Harrold, Thomas, Macon (6-S)
Harvey, C. W., Hogansville (68-GP—Life)
Harwell, C. W., Camilla (46-PH)
Haskins, R. M., Columbus (47-ObG—Sci)
Hastings, E. V., Augusta (54-Path)
Hatcher, Milford B., Macon (6-S)
Hathcock, William C., Atlanta (29-OALR)
Hauck, A. E., Atlanta (29-S)
Hausman, Robert, Decatur (29-Path)
Hawkins, Katrine Rawls, Sylvania (55-GP)

Hawkins, L. M., Blackshear (72-)
Hay, S. H., Toccoa (60-I)
Haynes, Grady O., Augusta (54- —Assoc)
Hazelhurst, W. Derrel, Macon (6-I)
Hazouri, Louis A., Camp Gordon (47-NS—Assoc)
Head, D. L., Zebulon (59-S)
Head, D. L., Jr., Thomaston (69-GP)
Head, Homer, Monroe (71-GP)
Head, M. M., Zebulon (59-GP—Life)
Heard, John P., Decatur (22-GP)
Hearin, David L., Atlanta (29-D)
Heaton, Samuel A., Beaufort, S. C. (35- —Assoc)
Hein, David E., Atlanta (29-I)
Hellenga, Irving D., Toccoa (60-GP)
Helms, William C., Atlanta (29-ObG—Assoc)
Helton, B. L., Sandersville (74-GP)
Helton, William S., Sandersville (74-GP—Assoc)
Henderson, Charles T., Marietta (17-S)
Hendrick, A. G., Perry (36-GP)
Hendricks, Willis M., LaGrange (68-ObG)
Hendrix, Arthur M., Canton (14-GP)
Hendrix, M. G., Ball Ground (13- —Life)
Hendry, G. T., Blackshear (72-GP—Life)
Hendry, Katherine McM., Blackshear (72-GP)
Hendry, William A., Blackshear (72-GP)
Henry, Charles G., Augusta (54-Or)
Henry, Charles M., Clarkesville (33-S)
Henry, George T., Barnesville (59-GP)
Henry, J. Lamont, Atlanta (29-I)
Henschen, Hal, Atlanta (29-S)
Hensley, E. A., Gibson (54-)
Herault, Pierre C., Jr., LaGrange (68-Anes)
Herman, E. C., LaGrange (60-S)
Herrmann, Lyle F., Hapeville (29-GP)
Hewell, Guy C., Atlanta (29-ObG)
Hickman, Bernard T., New Orleans, La. (29-R—Assoc)
Hicks, J. M., Brunswick (30-OALR)
Hicks, L. G., Jr., Clarkesville (33-Anes)
Hicks, Thomas J., McCaysville (7-Ob)
Hicks, W. G., Jackson (59-GP)
Hicks, W. Lynn, Macon (6-GP)
Hightower, John A., Brunswick (30-I)
Hill, Haywood N., Atlanta (29-I)
Hill, William H., Atlanta (29-S)
Hillis, W. W., Sardis (9- —Life)
Hillis, W. W., Jr., Sardis (9-GP)
Hilsman, J. H., Atlanta (29-I)
Hilsman, P. L., Albany (23-ObG)
Hines, John H., Roswell (29-GP)
Hirsch, Jack, Columbus (47-I)
Hitchcock, J. P., Augusta (54-S)
Hobbs, Armenious C., Jr., Columbus 47-Oph)
Hobby, A. Worth, Atlanta (29-Pul)
Hock, Charles W., Augusta (54-GE)
Hockenhull, John A., Atlanta (29-GP)
Hockett, William J., Jr., Ft. Mead, Md. (29- —Assoc)
Hodges, C. A., Dublin (42-OALR—Life)
Hodges, Fred B., Jr., Atlanta (29-Pr)
Hodges, J. H., Hapeville (29-Ob)
Hodges, John M., Marietta (17-S)
Hodges, Malcolm R., Macon (6-GP)
Hodges, W. A., Atlanta (29- —Life)
Hodgson, Fred G., Atlanta (29-Or—Life)
Hodnett, James D., Memphis, Tenn (29- —Assoc)

Hoffman, Byron J., Atlanta (29-I)
Hoffman, Frank, Savannah (11-ALR)
Hogan, J. T., Jr., Macon (6-GP)
Hogan, Ralph B., Atlanta (29- —Assoc)
Hogsette, Gerald B., Sylvania (55-S)
Holbrook, H. P., Tucker (22-GP)
Holden, William H., Macon (6-ALR)
Holder, F. P., Jr., Eastman (50-S)
Holder, J. S., LaGrange (68-S)
Holland, S. P., Blakely (58-GP)
Holliday, H. C., Athens (15-S)
Holliman, Henry D., Jr., Atlanta (29-U)
Hollis, Charles D., Jr., Albany (23-I)
Holloman, J. J., Savannah (11-GP)
Holloway, Charles E., Atlanta (29-S)
Holloway, George A., Atlanta (29-ObG)
Holman, C. M., Albany (23-ObG)
Holmes, Edgar C., Moultrie (19-S—Dec)
Holmes, L. P., Augusta (54-R)
Holmes, Walter R., Atlanta (29-G)
Holsenbeck, George H., Atlanta (29-U)
Holt, J. T., Baxley (1-GP)
Holton, C. F., Savannah (11-S)
Holtz, Louis, Carrollton (10-GP)
Homeyer, W. F., Jr., Macon (6-Anes)
Hook, Edward W., Jr., Atlanta (29-I—Assoc)
Hooker, James F., Waycross (72-PH)
Hoover, J. P., Rossville (70-GP)
Hoover, Richard D., Emory University (29-Or)
Hope, H. F., Atlanta (29- —Dec)
Hopkins, Anne, Savannah (11-I)
Hopkins, Enon C., Augusta (54-D)
Hopkins, William A., Atlanta (29-S)
Hoppe, L. D., Atlanta (29-Pd)
Horn, Edgar B., Columbus (47-S)
Hortman, H. C., Rome (27-ObG)
Horton, A. L., Cartersville (4-GP—Life)
House, John O., Atlanta (29-Anes)
Houser, Frank M., Macon (6-GP)
Houston, W. H., Colquitt (58-)
Howard, C. L., Pelham (46-S)
Howard, Charles K., Atlanta (29-S)
Howard, I. B., Williamson (59-GP—Life)
Howard, John C., Athens (15-OALR)
Howard, John M., Emory University (29-)
Howard, Lee, Savannah (11-Path)
Howard, Lee, Jr., Savannah (11-Path)
Howard, Marcus L., Dahlonega (34-GP)
Howard, P. M., College Park (29- —Life)
Howard, Thomas J., Augusta (54-GP)
Howell, Barbara P., Ft. McPherson (29-)
Howell, James C., Jackson (59-GP)
Howell, Stacy C., Atlanta (29-Oph)
Howell, Tom S., Jr., Atlanta (29- —Assoc)
Howell, William Harvey, Cartersville (4-GP)
Howkins, John S., Savannah (11-)
Hubert, M. A., Athens (15-U)
Hudgins, William B., Atlanta (29-I—Assoc)
Hudson, Jack, Augusta (54-GP)
Hudson, Paul L., Atlanta (29- —Assoc)
Hughes, D. James, Atlanta (29-I)
Hughes, J. M., Glennville (62-)
Hugheston, Jack C., Columbus (47-Or)
Huguley, Charles M., Jr., Emory University (29-I)
Huguley, G. P., Atlanta (29- —Life)
Huie, Lynn M., Monroe (71-GP)
Huie, Ralph A., Jr., Atlanta (29-I)
Huie, Robert E., Atlanta (29-GP)
Hulsey, John M., Jr., Gainesville (34-GP)
Hunnicut, J. A., Athens (15-GP—Life)
Hunt, A. H., Lithonia (22-)
Hunt, James, Mt. Vernon (75-GP)
Hunt, K. S., Griffin (59-S)

Hunter, Conway, Atlanta (29-ObG)
Hurst, J. Willis, Emory University (29-I)
Hurt, Marion W., Sandersville (74-GP)
Hutchins, Harry, Buford (13-GP)
Hutchins, W. J., Buford (13-GP)
Hutchinson, W. L., LaGrange (68-ObG)
Hutchison, Norton H., Trenton (70-GP)
Hutto, George M., Columbus (47-R)
Hyde, H. P., Copperhill, Tenn. (7-)
Hyden, William U., Trion (12-)
Hydrick, Peter, College Park (29-ObG)

I

Inglis, E. P., Jr., Marietta (17-)
Inman, J. S., Jr., Albany (23-ObG)
Inman, William O., Jr., Brunswick (30-GP)
Ireland, Charles R., Macon (6-I)
Irwin, Charles Edwin, Atlanta (29-Or)
Isenberg, Sidney, Atlanta (29-P)
Isler, J. N., Meigs (65-GP—Life)
Ivey, John C., Atlanta (29-S)

J

Jackson, Bruce, Newnan (20-)
Jackson, Gordon W., Calhoun (31-GP)
Jackson, Henry C., Manchester (45-GP)
Jackson, J. H., Barnesville (41-GP)
Jackson, Joseph M., Folkston (72-GP)
Jackson, T. W., Manchester (45- — Life)
Jackson, Zach W., Atlanta (29-Oph)
Jacobs, Cecil F., Jesup (75-)
Jacobs, Ivey, Waycross (72-GP)
Jacobs, John L., Atlanta (29-Al)
James, David F., Atlanta (29-I)
James, L. P., Macon (6-)
Jardine, Dan A., Douglas (18-S)
Jarrat, W. D., Macon (6-Oph)
Jarrell, Floyd C., Jr., Columbus (47-OALR)
Jarrett, Henry K., Jr., Macon (6-U)
Jefford, T. C., Sylvester (79- —Life)
Jelks, Louis R., Reidsville (62-S)
Jenkins, Ben H., Newnan (20-OALR)
Jenkins, H. B., Donalsonville (21-S)
Jenkins, M. K., Atlanta (29- —Life)
Jenkins, C. W., Lindale (27-GP)
Jenkins, W. F., Columbus (47-R)
Jennings, C. M., Marietta (17-I)
Jennings, E. R., Brunswick (30-S)
Jennings, Henry S., Jr., Gainesville (34-I)
Jennings, James L., Atlanta (29-OALR)
Jennings, W. D., Augusta (54-GP— Assoc)
Jennings, W. D., Jr., Augusta (54-S)
Jerech, Henrietta, Columbus (47-GP)
Jernigan, C. S., Sparta (49- —Life)
Jernigan, H. Walker, Atlanta (29-Or)
Jernigan, Sterling H., Atlanta (29-S)
Johnson, A. M., Valdosta (56-Pd)
Johnson, A. S., Jr., Elberton (24-GP)
Johnson, A. S., Sr., Elberton (24-OALR —Life)
Johnson, C. D., Columbus (47-GP)
Johnson, C. V., New York, N. Y. (33- —Assoc)
Johnson, E. G., Chattanooga, Tenn. (70-S)
Johnson, G. Hugo, Jr., Savannah (11-)
Johnson, J. A., Manchester (45-GP)
Johnson, J. E., Jr., Elberton (24-)
Johnson, J. F., Macon (6-I)
Johnson, James A., Jr., Manchester (37-GP)
Johnson, Julius T., Midville (9-GP)
Johnson, McClaren, Atlanta (29-GE)
Johnson, R. L., Douglas (18-GP)
Johnson, Ralph N., Rome (27-S)
Johnson, Roy J., Jr., Fitzgerald (5-GP)
Johnson, Thomas D., Albany (23-I)
Johnson, W. A., Elberton (24-)
Johnston, G. A., Macon (6- —Assoc)
Johnston, Thomas H., Brunswick (30-)

Johnston, Victoria I., Brunswick (30-GP)
Joiner, H. G., Douglas (18-GP)
Joiner, Hartwell, Gainesville (34-I)
Joiner, R. M., Moultrie (19-Pd)
Jolley, Fleming L., Atlanta (29-NS)
Jolley, J. S., Homer (3-GP)
Jones, A. B., Jr., Quitman (65-GP)
Jones, A. J., Jacksonville (64-GP—Life)
Jones, A. P., Griffin (59-GP)
Jones, Carl C., Jr., Atlanta (29-Al)
Jones, Charles S., Atlanta (29-S)
Jones, Eugenia Cuvillier, Atlanta (29-I)
Jones, Forrest D., Atlanta (29-Pd)
Jones, G. Frank, Jr., Augusta (54-S)
Jones, H. T., West Point (68-)
Jones, Henry B., Jr., Gray (6-)
Jones, Jabez, Savannah (11- —Life)
Jones, John P., Macon (6-Pd)
Jones, R. E., Tifton (66-GP)
Jones, R. T., III, Canton (14-GP)
Jones, Rembert C., Elberton (24-GP— Sci)
Jones, Robert T., Lafayette (70-)
Jones, Rudolph W., Jr., Macon (6-I)
Jones, W. R., Columbus (47-Pd)
Jordan, William K., Macon (6-ObG)
Jordan, Willis P., Columbus (47-U)
Jordon, Charles G., Eatonton (2-GP)
Joseph, Alfred, College Park (29-Pd)
Josephs, Alvin D., Atlanta (29-I)
Jungck, E. C., Augusta (54-)

K

Kaley, J. S., Marietta (17-S)
Kane, Eugene C., St. Simons Island (30-GP)
Kane, Thomas M., Atlanta (29-G)
Kanter, W. W., Savannah, (11-)
Kanthak, F. F., Atlanta (29-PL)
Karp, Herbert R., Durham, N. C. (29-I —Assoc)
Kaufman, James A., Atlanta (29-I)
Kay, J. B., Byron (6-GP)
Kay, James B., Jr., Augusta (54-U)
Keen, O. F., Macon (6-S)
Keiter, William G., Greensboro (49-)
Keller, A. Paul, Jr., Athens (15-OALR)
Kelley, A. J., Savannah (11-ObG)
Kelley, D. C., Lawrenceville (13-GP)
Kelley, J. Weldon, Griffin (59- — Assoc)
Kelley, L. H., Atlanta (29-GP)
Kelley, W. A., Atlanta (29-GP)
Kellum, J. M., Thomaston (69-S)
Kelly, G. Lombard, Augusta (54-P)
Kelly, Gordon M., Augusta (54-S)
Kelly, James D., Atlanta (29-S)
Kelly, Robert P., Jr., Emory University (29-Or)
Kemper, Clifton G., Atlanta (29-GP)
Kendall, Randall P., Columbus (47- — Dec)
Kennedy, F. D., Baxley (1-GP)
Kenyon, J. M., Richland (53- —Life)
Kerr, William K., Chamblee (22-GP)
Ketchum, W. H., Rome (27-Pul)
Ketrion, Hubert W., Atlanta (29-I— Assoc)
Key, Claude T., Atlanta (29- —Life)
Killam, F. H., Greensboro (49-Oph)
Killeffer, John J., Chattanooga, Tenn. (70-Cr)
Kilpatrick, Charles M., Augusta (54-OALR)
King, C. Richard, Atlanta (29-S)
King, Harry C., Griffin (59-ObG)
King, J. Dudley, Atlanta (29-R)
King, J. L., Macon (6-I)
King, J. Lon, Jr., Macon (6-ObG)
King, J. T., Thomasville (65-OALR)
King, James T., Atlanta (29-ALR)
King, Lewell S., College Park (29-S)

King, O. D., Bremen (10-)
King, Richard E., Atlanta (29-Or)
King, Ruskin, Savannah (11-Pd)
King, William R., Jr., Griffin (59-S)
Kinnard, George P., Newnan (20-U)
Kinser, George H., Terre Haute, Ind.
Kirkland, S. A., Atlanta (29-U)
Kirkland, W. P., Manchester (45-GP)
Kiser, Ellen Finley, Atlanta (29-P)
Kiser, William H., Jr., Atlanta (29-P)
Kiszka, Edward F., Emory University (29- —Assoc)
Kitchens, O. W., Byromville (26-GP)
Kitchens, S. B., Lafayette (70-GP)
Kitchens, William C., Athens (15-I)
Kite, J. H., Atlanta (29-Or)
Klemann, Gilbert, Augusta (54-I)
Klugh, George F., Atlanta (29-Path)
Knight, A. M., Jr., Waycross (72-I)
Koff, S. A., Atlanta (29-P)
Kraft, H. N., Atlanta (29-I)
Krantz, Simon, Atlanta (29- —Assoc)
Kravtin, A. J., Columbus (47-Pd)
Krugman, Philip I., Atlanta (29-ObG)
Kugler, Margaret M., Chamblee (29- —Assoc)
Kurtz, Joseph L., Atlanta (29-Or)
Kusnitz, Morris J., Jr., Alamo (57-)

L

LaGuette, Henry F., Boston, Mass. (29-U—Assoc)
Lahman, Rose A., Atlanta (29-ObG)
Lamb, Charles C., Albany (23-GP)
Lamm, J. H., Atlanta (29-I)
LaMotte, Irene F., Augusta (54- — Assoc)
Lamson, Thomas H., Arlington (58- — Assoc)
Lancaster, E. M., Shady Dale (38-GP)
Lancaster, Homer H., Gainesville (34-GP)
Land, Polk S., Columbus (47-GP)
Landham, J. W., Griffin (59-)
Lane, G. M., Dublin (42-S—Assoc)
Lane, Nell Kenney, Dublin (42-GP— Assoc)
Lane, R. E., Atlanta (29-)
Lang, G. H., Savannah (11-OALR— Life)
Lang, Lewis R., Calhoun (31-GP)
Lange, J. Harry, Atlanta (29-Pd)
Lange, Stephen J., Savannah (11-)
Langmuir, Alexander D., Atlanta (29- —Assoc)
Lanier, L. Fielding, Sylvania (55-Pd— Life)
Lanier, Lonnie Richard, Jr., Albany (23-ObG)
Lapides, Leon, Columbus (47-ALR)
Lawless, T. F., Savannah (11-)
Lawrence, Charles E., Atlanta (29-Anes)
Lawrence, J. C., Dublin (42- —Assoc)
Laws, Clarence L., Atlanta (29-Al)
Leadingham, R. S., Murfreesboro, Tenn. (29-I—Life)
Leaphart, J. A., Jesup (75-I)
Lee, C. A., Atlanta (29-GP)
Lee, F., Lansing, Augusta (54-I)
Lee, H. G., Millen (40-GP)
Lee, Howard B., Decatur (22-GP)
Lee, Lawrence, Jr., Savannah (11-I)
Lee, Walter E., Jr., Waycross (72-GP)
Leigh, Ted F., Emory University (29-R)
Leitheiser, Karl A., Durham, N. C. (54-Pd—Assoc)
LeMaistre, Charles A., Atlanta (29-I)
Lennard, O. D., Sandersville (74-S)
Leonard, Robert, Augusta (54-OALR)
Leonard, William P., Atlanta (29-S)
Leroy, Albert G., Thomson (44-GP)
Leslie, John T., Decatur (22-Pd)

Lester, J. E., Marietta (17-PH)
 Lester, William M., Atlanta (29-Ob)
 Letton, A. Hamblin, Atlanta (29-S)
 Lever, Joseph E., Sandersville (74-GP)
 Levin, Harold B., Atlanta (29-D)
 Levin, Jack M., Atlanta (29-Pr)
 Levington, H. L., Savannah (11-GP)
 Levy, Jack H., Augusta (54-R)
 Levy, Louis K., Atlanta (29-I)
 Levy, M. S., Smyrna (17-Ind)
 Levy, Theodore, Brooklyn, N. Y. (54-
 —Assoc)
 Levy, Tracy, Seattle, Wash. (65-I)
 Lewis, James W., LaGrange (68-Pd)
 Lewis, John R., Jr., Atlanta (29-PL)
 Lewis, S. J., Augusta (54-OALR—Life)
 Lewis, T. K., Jr., Atlanta (29-P)
 Lewis, William Earl, Macon (6-S)
 Linch, A. O., Atlanta (29-S)
 Lindsey, W. F., Hahira (56-)
 Lineback, Merrill I., Atlanta (29-ALR)
 Link, Vernon B., Atlanta (29- —Assoc)
 Lipman, Bernard S., Atlanta (29-I)
 Lippitt, William H., Savannah (11-S)
 Lipscomb, J. Watts, Forest Park (29-I)
 Lipscomb, W. E., Cumming (13- —
 Life)
 Lipton, Harry R., Atlanta (29-P)
 Little, Alex G., Jr., Valdosta (56-S)
 Little, Frank A., Brookhaven (65-Anes
 —Assoc)
 Little, G. H., Trion (12-GP)
 Little, R. N., Summerville (12-)
 Little, Tom F., Ocilla (5-)
 Litton, James H., Tucker (22-GP)
 Logan, J. C., Plains (61- —Life)
 Logue, R. Bruce, Emory University (29-
 I)
 Lokey, Hugh M., Atlanta (29-OALR—
 Life)
 Lokey, Julian L., Kinston, N. C. (54-I—
 Assoc)
 Long, Leonard, Atlanta (29-R)
 Long, Stewart M., Atlanta (29-S)
 Long, W. V., Savannah (11-S)
 Longino, D. R., Atlanta (29- —Assoc)
 Longino, Grady Estes, Dublin (29-I)
 Looper, Ben Keith, Canton (14-ObG)
 Lott, Oscar H., Savannah (11-GP)
 Love, William G., Jr., Columbus (47-S)
 Lovell, Wood W., Atlanta (29-Or)
 Lovett, K. S., Metter (8-GP)
 Lovett, Lindsey F., Metter (8-GP)
 Lowance, Mason I., Atlanta (29-Al)
 Lucas, I. M., Albany (23-GP—Life)
 Lucas, Paul Warren, Tifton (66-OALR)
 Lucas, W. H., Cedartown (51-GP—Life)
 Lumsden, Thomas N., Clarksville (33-
 GP)
 Lunsford, Guy G., Atlanta (29- —Life)
 Luther, Charles G., Jr., Augusta (54-S)
 Lynn, S. C., Savannah (11-Pul)
 Lyon, Harry C., Atlanta (29-GP)

M

Mabon, Robert, Atlanta (29-NS)
 Maholick, Leonard T., Columbus (47-
 P)
 Main, Emory H., College Park (29-GP)
 Mainor, Robert D., Smyrna (17-GP)
 Major, Robert C., Augusta (54-S)
 Maley, Virginia H., Cartersville (34-PH)
 Malloy, Martin L., Vienna (26-)
 Malone, Bert H., Brunswick (30-R)
 Malone, O. T., Atlanta (29-)
 Malone, Thomas P., Atlanta (29-P)
 Malone, Virginia G., Atlanta (29-I—
 Assoc)
 Maloy, C. J., McRae (64-GP)
 Manchester, P. Thomas, Jr., Atlanta (29-
 Oph)
 Mandel, Emanuel Emil, Chicago, Illi-
 nois (29- —Assoc)

Maner, E. N., Savannah (11-OALR—
 Assoc)
 Manganiello, Louis O. J., Augusta (54-
 NS)
 Manget, J. D., Jr., Atlanta (29-GP)
 Mann, David S., Macon (6-)
 Mann, Frank R., McRae (64-GP)
 Mann, Frank R., Jr., McRae (64-)
 Manter, John T., Augusta (54-)
 Margeson, Richard Clyde, Atlanta (29-
 Assoc)
 Marks, E. S., Marietta (17-S)
 Marshall, A. Smoak, Fort Valley (36-
 GP)
 Martens, Lester J., Rome (27-I)
 Martin, Anthony J., Sarasoto, Florida
 (29- —Assoc)
 Martin, Dan A., Atlanta (29-S)
 Martin, Donald S., Chamblee (29- —
 Assoc)
 Martin, Elizabeth, Atlanta (29-ObG)
 Martin, F. M., Shellman (53- —Life)
 Martin, J. D., Jr., Emory University
 (29-S)
 Martin, J. J., Dawson (29- Assoc)
 Martin, J. O., Macon (6-Oph)
 Martin, James B., Edison (58-GP)
 Martin, John M., Augusta (54-I)
 Martin, R. M., Jr., Conyers (48-GP)
 Martin, R. V., Savannah (11- —Life)
 Martin, Robert B., III, Cuthbert (53-S)
 Martin, T. M., Jr., Bowdon (10-)
 Martin, W. O., Jr., Atlanta (29-Oph)
 Martin, W. P., Summerville (12-GP)
 Martin, Walter D., Dawson (53-GP)
 Mashburn, James S., Cumming (13-S)
 Mashburn, Marcus, Cumming (13-GP)
 Mashburn, Marcus, Jr., Cumming (13-
 ObG)
 Mason, Eugene A., Folkston (72-)
 Mason, M. H., Duluth (13-GP)
 Mason, Wiley Roy, Jr., Emory Univer-
 sity (29-I)
 Mass, Max, Macon (6-R)
 Massee, Joseph C., Atlanta (29-I)
 Massenburg, G. Y., Macon (6-S)
 Massengale, L. R., Augusta (54-Pd)
 Massey, Clayton M., Waycross (72-Pd)
 Massey, W. F., Chester (50-GP)
 Mathis, W. H., Jr., Marietta (17-R)
 Matthew, Robert A., Albany (23-Anes)
 Matthews, Lawrence P., Atlanta (22-
 ObG)
 Matthews, Thomas V., Atlanta (29-)
 Matthews, W. E., Augusta (54-OALR)
 Matthews, Warren B., Marietta (17-
 Path)
 Mattox, B. B., Elberton (24- —Assoc)
 Maughon, J. S., Valdosta (56-GP)
 Mauldin, John T., Atlanta (29-S)
 Mauldin, John W., Lawrenceville (13-
 GP)
 Maxwell, Edgar J., Jr., Thomson (44-S)
 May, E. R., Lincolnton (54- —Life)
 Mayher, J. W., Columbus (47-ALR)
 Mayher, W. E., Columbus (47-S)
 Mayo, Earl A., Jr., Richland (53-)
 Mays, J. R. S., Macon (6-P)
 Mazo, Milton, Savannah (11-Pd)
 McAllister, Harry M., Atlanta (29-Oph)
 McAllister, Robert W., Macon (6-U)
 McArthur, Charles E., Cordele (26-GP)
 McArthur, John D., Lyons (57-)
 McBryde, T. E., Rockmart (51-Ind—
 Life)
 McCain, John R., Atlanta (29-ObG)
 McCall, Charles S., Jr., Albany (23-I)
 McCall, J. T., Jr., Rome (27-S)
 McCall, M. N., Jr., Acworth (17-GP)
 McCall, W. R., LaGrange (68-Anes—
 Life)
 McCarver, W. C., Vidette (9- —Life-Dec)

McCarver, W. C., Jr., Gainesville (34-
 GP)
 McClelland, W. Spence, Atlanta (29-I)
 McClung, R. H., Atlanta (29-S)
 McClure, E. Ruth, Marietta (17-ObG)
 McClure, James H., Atlanta (29-ObG—
 Assoc)
 McClure, John N., Atlanta (29-S)
 McClure, Robert E., Atlanta (29- —
 Assoc)
 McCollum, R. Roy, Jr., Kingsland (72-)
 McCollum, William, Thomasville (65-
 GP)
 McConnell, Bright, Augusta (54-Or—
 Assoc)
 McCord, J. R., Ocala, Florida (29- —
 Life)
 McCord, Ralph B., Rome (27-OALR)
 McCoy, John F., Moultrie (19-GP)
 McCoy, John M., Atlanta (29-I)
 McCoy, W. R., Folkston (72-GP)
 McCrum, B. A., Gainesville (34-ObG)
 McCulloh, Hugh, West Point (68-)
 McCurdy, Willis T., Stone Mountain
 (22-GP)
 McCurry, W. E., Hartwell (35- —Life)
 McDaniel, J. G., Atlanta (29-S)
 McDaniel, J. Z., Albany (23-U)
 McDonald, E. M., Winder (37-)
 McDonald, H. P., Atlanta (29-U)
 McDonald, J. J., Athens (15-S)
 McDonald, Lewis H., Atlanta (29-S)
 McDonald, Paul, Bolton (29- —Life)
 McDonald, R. H., Newnan (20-S)
 McDonough, L. Allen, Atlanta (29-Pd)
 McDougall, J. Calhoun, Atlanta (29-
 ALR)
 McElhannon, F. M., Winder (37-GP)
 McElreath, F. T., Jr., Tennille (74-GP)
 McElroy, Joseph D., Atlanta (29-P)
 McEveen, J. M., Brooklet (8- —Life)
 McEver, V. W., Jr., Warner Robins (6-
 GP)
 McGahee, Robert C., Augusta (54-Pd)
 McGarity, William C., Emory University
 (29-S)
 McGeachy, Thomas E., Decatur (22-GP)
 McGeary, W. C., Madison (49-GP)
 McGeary, W. C., Jr., Madison (49-GP)
 McGee, Roy W., Atlanta (29-PH)
 McGee, Theodore J., Columbus (47-S—
 Assoc)
 McGehee, John M., Cedartown (51-S)
 McGhee, Earl T., Dalton (76-GP)
 McGinty, A. Park, Atlanta (29-I)
 McGinty, Howard C., Augusta (54-S)
 McGinty, W. R., Moultrie (19-S)
 McGoldrick, Thomas A., Jr., Savannah
 (11-I)
 McGoogan, M. T., Waycross (72-S)
 McInnes, George F., Augusta (54-PL)
 McKee, David S., Atlanta (29-Pd)
 McKemie, H. M., Albany (23-S)
 McKemie, W. Frank, Albany (23-)
 McKenzie, J. M., Thomaston (69-)
 McKnight, Robert R., Augusta (54-Or)
 McLain, Ernest K., Augusta (54-Pul—
 Assoc)
 McLaughlin, C. K., Macon (6-Oph)
 McLean, Jay, Savannah (11-S)
 McLeod, John W., Moultrie (19-S)
 McLoughlin, Christopher J., Atlanta (29-
 I)
 McMath, William Bates, Americus (61-
 OALR)
 McMichael, Robert S., Macon (6-GP)
 McMichael, V. H., Macon (6-GP)
 McMillan, E. C., Jr., Macon (6-S)
 McNeely, Henry H., Toccoa (60-GP)
 McNeill, A. A., Jr., Camilla (46-)
 McNiece, Estelle, Atlanta (29-Pd)

- McPherson, John H. T., Athens (15-S)
 McPherson, Thomas C., Atlanta (29-Pd)
 McRae, D. B., McRae (64-S)
 McRae, D. R., Jr., Augusta (54-S)
 McRae, Floyd W., Atlanta (29-S)
 McWhorter, M. R., Columbus (47-GP)
 Meaders, Henry D., Marietta (17-ObG)
 Mealing, H. G., Augusta (54-I)
 Meeks, Calvin Stewart, Jr., Douglas (18-GP)
 Meeks, Jesse L., Gainesville (34-GP)
 Meissner, Tom Otto Walter, Athens (15-
 Oph—Dec)
 Mendenhall, W. A., Chamblee (22-GP)
 Mercer, J. E., Vidalia (57-GP)
 Mercer, Joseph B., Brunswick (30-GP)
 Meriwether, W. W., Macon (6-)
 Merren, David D., Albany (23-)
 Merrill, Arthur J., Atlanta (29-I)
 Merritt, Hinton J., Colquitt (58-GP)
 Merritt, James W., Colquitt (58-GP)
 Meserve, Francis Bruce, Warner Rob-
 ins (6-)
 Mestre, Ricardo, Marietta (29-R)
 Metts, James C., Savannah (11-I)
 Meyer, George W., Metter (8-)
 Michel, H. M., Augusta (54- —Assoc)
 Mickel, Carey A., Jr., Elberton (24-S)
 Middlebrooks, T. W., Union Point (49-)
 Middleton, D. S., Rising Fawn (70-
 GP—Life)
 Middleton, O. D., Ludowici (67-GP)
 Miles, Franklin C., New Orleans, La.
 (29-NS)
 Milford, J. Hubert, Hartwell (35-GP)
 Miller, Abraham, Augusta (54-ObG)
 Miller, E. V., Columbus (47-GP—Sci)
 Miller, Hal C., Atlanta (29- —Assoc)
 Miller, John M., Augusta (54-I)
 Miller, Lila Bonner, Atlanta (29-I)
 Miller, Linus J., Atlanta (29-Anes)
 Miller, Robert E., Jesup (75-)
 Milligan, King W., Augusta (54-I—Life)
 Mills, C. W., Jr., Atlanta (29-I)
 Mims, F. C., Decatur (29- —Assoc)
 Mims, Harry W., Charleston, S. C. (45-
 PM)
 Mims, Oscar M., Thomasville (65-I)
 Mincey, Rollo J., Jr., Thomaston (69-
 ObG)
 Minchew, B. H., Waycross (72-OALR)
 Minnich, Fredric R., Atlanta (29-ObG)
 Minnich, William R., Atlanta (29-I)
 Minor, H. W., Atlanta (29-I—Life)
 Mitchell, Charles H., Washington, D. C.
 (29- —Assoc)
 Mitchell, Frank B., Jr., Brunswick (30-S)
 Mitchell, G. L., Decatur (22-I)
 Mitchell, J. B., Porterdale (48-GP)
 Mitchell, J. T., LaGrange (68-R)
 Mitchell, L. C., Columbus (47-)
 Mitchell, Marvin A., Atlanta (29-S)
 Mitchell, W. C., Smyrna (17-GP)
 Mitchell, William E., Atlanta (29-S)
 Mixon, George E. Palmetto (20-GP)
 Mixson, E. Harry, Valdosta (56-)
 Mixson, Joyce F., Jr., Valdosta (56-
 ObG)
 Mixson, Joyce F., Sr., Valdosta (56-GP
 —Life)
 Mixson, W. D., Waycross (72- —Life)
 Mize, E. G., College Park (29-ObG)
 Mobley, John W., Thomasville (65-D)
 Mobley, W. E., Macon (6- —Assoc)
 Molyneaux, E. W., LaGrange (68-GP)
 Monaco, A. Ralph, Columbus (47-Path)
 Moncrief, W. M., Atlanta (29-GP)
 Monfort, John M., Atlanta (29-I)
 Montero, Enrique, Griffin (59-Anes)
 Montgomery, R. C., Butler (63-)
 Montgomery, R. C., II, Butler (63-)
 Moody, Raymond A., Macon (6-GP)
 Mooney, John, Jr., Statesboro (8-S)
 Moore, C. W. C., Rome (27-I)
 Moore, Cliff, Jr., Rome (27-S)
 Moore, Clifford, Lindale (27-GP—Life)
 Moore, Ed L., Statesboro (8-OALR)
 Moore, Haywood L., Brunswick (30-I)
 Moore, R. M., Waleska (14- —Life)
 Morgan, F. W., Douglasville (10-)
 Morgan, Frank E., Jr., Decatur (22-R)
 Morgan, Horace L., Arlington (58-GP)
 Morgan, J. C., West Point (68-S—Life)
 Morgan, James C., Jr., West Point (68-
 OALR)
 Morris, Albert L., Fairburn (29-GP)
 Morris, J. L., Alpharetta (29-GP—Life)
 Morris, S. L., Jr., Atlanta (29-S)
 Morrison, Howard J., Savannah (11-Pd)
 Morrison, William N., Atlanta (29- —
 Assoc)
 Morse, Chester W., Decatur (22-GP)
 Morton, John B., Thomasville (65-P)
 Moseley, E. E., Donaldsonville (21-)
 Mosely, H. G., Atlanta (29-)
 Moseley, Teddy C., Atlanta (29- —
 Assoc)
 Moses, Alice, Phenix City, Alabama (47-
 —Life)
 Moses, W. M., Uvalda (57-)
 Moss, T. H., Rome (27-ObG)
 Moss, W. L., Athens (15- —Assoc)
 Mountain, G. W., Augusta (54- —
 Assoc)
 Moyer, C. G., Dublin (42- —Life)
 Moyer, R. J., Adrian (25-GP)
 Muecke, H. W., Waycross (72-Pd)
 Mulherin, C. S., Augusta (54-S—Assoc)
 Mulherin, Charles M., Augusta (54-ObG)
 Mulherin, F. X., Augusta (54-GP—Life)
 Mulherin, Joseph L., Augusta (54-S)
 Mulherin, Philip A., Augusta (54-Pd)
 Mulkey, A. P., Millen (40-)
 Mulkey, Q. A., Millen (40-S)
 Mull, J. H., Rome (27-S)
 Mullen, Sanford Allen, Minneapolis,
 Minnesota (29-Path—Assoc)
 Mullins, D. F., Augusta (54-Path)
 Mullins, James N., Chatsworth (76-GP)
 Munn, E. K., Columbus (47-ObG)
 Murdock, J. W., Dublin (42- —Assoc)
 Murphy, Alex T., Augusta (54-I)
 Murphy, Fred E., Jr., Thomasville (65-
 Or)
 Murphy, Michael V., Jr., Atlanta (29-I)
 Murphy, Ralph A., Jr., Atlanta (29-I)
 Murphy, William J., Atlanta (29-PH)
 Murray, G. S., Columbus (47- —Life)
 Murray, Hamil, Gainesville (34-Path)
 Murray, Samuel D., Atlanta (29-S)
 Musarra, E. A., Marietta (17-GP)
 Muse, J. Phillip, Brunswick (30-Pd)
 Myers, Martin T., Atlanta (29-Gr)

N

 Nabors, Dewey T., Atlanta (29-)
 Nalley, William B., Helen (34-ObG—
 Assoc)
 Nardin, Gene, Atlanta (29-I)
 Nardone, A. J., Decatur (22-S)
 Nash, D. A., Savannah (11-)
 Nash, T. C., Philomath (78-)
 Nathan, Daniel E., Fort Valley (6-GP)
 Nation, Thomas C., Atlanta (29-Path—
 Assoc)
 Neal, Jule C., Jr., Macon (6-ObG)
 Neal, L. G., Cleveland (34-GP)
 Neal, L. G., Jr., Cleveland (34-GP)
 Neel, Julian B., Thomasville (65-S)
 Neely, F., Levering, Atlanta (29-I)
 Neighbors, J. B., Jr., Athens (15-I)
 Neill, Frank K., Albany (23-GP)
 Nellans, C. T., Roswell (29- —Assoc)
 Nelson, Richard M., Atlanta (29- —
 Life)
 Nesbit, F. C., Covington (48-GP)
 Neuberger, S. Charlotte, Macon (6-)
 Nevil, J. L., Metter (8-GP)
 Neville, R. L., Savannah (11-S)
 Newbaker, B. A., Dublin (42- —Assoc)
 Newlin, Lucian K., Valdosta (56-)
 Newman, Harvey M., Gainesville (34-
 Pd)
 Newman, W. A., Macon (6-Or)
 Newsom, Bruce C., Columbus (47-S)
 Newsom, N. J., Sandersville (74-I)
 Newsome, Emory G., Sandersville (74-
 GP)
 Newton, Ralph G., Macon (6-S)
 Newton, Ralph G., Jr., Macon (6-U)
 Nichols, Fenwick T., Jr., Savannah (11-
 I)
 Nichols, Pomeroy, Augusta (54-NS)
 Nichols, W. H., Canton (14-)
 Nicholson, George T., Cornelia (33-GP)
 Nicholson, J. H., Madison (49-S)
 Nicolson, W. P., III, Gainesville (34-
 U)
 Nicolson, W. Perrin, Atlanta (29-S)
 Niles, George A., Jr., Atlanta (29-ObG)
 Nippert, Philip H., Atlanta (29-D)
 Noel, Malcolm E., Atlanta (29-GP—
 Life)
 Norman, Lewis G., Jr., West Point
 (68-S)
 Norris, Jack C., Atlanta (29-CP)
 Norton, J. H., Jr., Cave Spring (27-GP)
 Norton, R. F., Rome (27-ObG)
 Norvell, J. T., Augusta (54-GP)
 Norwood, Sam W., Atlanta (29-ObG)
 Nunnally, Harry B., Monroe (71-GP)
 Nutt, J. J., Bowdon (10-GP)

O

 O'Conner, Frank L., Rossville (70-S)
 O'Daniel, J. F., Dublin (42-GP)
 O'Daniel, John Y., Ellijay (7-)
 Oden, John W., St. Petersburg, Florida
 (12- —Life)
 Oden, Lewis H., Jr., Panama City, Fla.
 (72- —Assoc)
 Oden, T. E., Blackshear (72- Assoc)
 Odom, Hart S., Woodbury (45-GP)
 Ohlmacher, Albert Phillip, Baxley (1-S)
 Olds, Bomar, College Park (29-OALR)
 Cliphant, J. B., Adel (56-)
 Oliver, Robert Lee, Savannah (11-S)
 Olley, James F., Atlanta (29-CP)
 Olliff, H. H., Register (8-GP)
 Olmstead, G. T., Savannah (11-OALR—
 Life)
 Olnick, Herbert M., Macon (6-R)
 O'Neal, Buford L., Atlanta (29-OALR)
 O'Neal, John B., III, Elberton (24-S)
 O'Neal, Phyllis J., Elberton (24-)
 O'Neal, R. S., LaGrange (68-GP—Life)
 O'Neill, J. C., Savannah (11-)
 Oppenheimer, R. H., Jacksonville, Fla.
 (29-I)
 O'Quinn, Silas E., Douglas (18-GP)
 O'Rear, Harry B., Augusta (54-Pd)
 Orr, William W., Macon (6-Pd)
 Orton, Sarah P., Rome (27-Pul)
 Osborne, E. S., Savannah (11-OALR—
 Life)
 Osborne, V. W., Atlanta (29-GP)
 Osborne, W. W., Savannah (11-ObG)
 Oshlag, Abraham M., Griffin (59-I)
 Osteen, W. L., Savannah (11-Anes)
 Otto, Walter W., Savannah (11-PH)
 Overby, Nicholas, Sandersville (74-
 OALR)
 Owens, B. G., Valdosta (56-S)
 Owens, J. D., Abbeville (50-GP)
 Owings, Richard S., Augusta (54-Pd—
 Assoc)

P

 Pacifici, Joseph, Savannah (11-)

Palmer, C. B., Covington (48-GP)
 Palmer, J. I., Thomasville (65-ObG)
 Palmer, J. W., Ailey (57-)
 Palmer, John R., Jr., Green Cove Spring, Florida (54- —Assoc)
 Park, Emory R., LaGrange (68-GP—Life)
 Parker, J. Lee, Greensboro (49-GP)
 Parker, T. L., Douglas (18-S)
 Parkerson, S. T., McRae (64-GP)
 Parks, Francis M., Carrollton (10-GP)
 Parks, Harry, Atlanta (29-I)
 Parks, Joseph W., Jr., Newnan (20-GP)
 Parnell, R. Parks, Jr., Smyrna (29-GP)
 Parrish, L. H., Albany (23-Ob)
 Parrott, Jesse Lyle, Hahira (56-GP)
 Paschal, J. Dean, Albany (23-Pd)
 Patillo, Charles E., Decatur (22- —Assoc)
 Patrick, E. V., Carrollton (10-)
 Patterson, J. C., Cuthbert (53-S)
 Patterson, Joseph H., Atlanta (29-Pd)
 Patterson, Robert L., Chattanooga, Tennessee (70-D)
 Patterson, Virginia N., Norfolk, Virginia (30-Pd)
 Pattillo, G. M., Austell (17-)
 Patton, Samuel E., Macon (6-I)
 Paty, Robert M., Jr., Covington (48-S)
 Paulk, J. R., Moultrie (19-OALR)
 Paullin, William L., Jr., Atlanta (29-I)
 Payne, R. F., Augusta (54-PH)
 Peacock, Lamar B., Atlanta (29-I)
 Peacock, Thomas G., Milledgeville (2-P)
 Pearson, F. O., Macon (6-PH)
 Peek, Stanley L., Jr., Atlanta (29-S)
 Pendergrass, R. C., Americus (61-R)
 Pendergrast, William J., Chevy Chase, Maryland (29-S)
 Pendley, Walter O., Rome (27-GP)
 Peniston, J. B., Newnan (20-)
 Penland, J. E., Waycross (72-GP)
 Pennington, Weems R., Lincolnton (78-GP)
 Pentecost, M. P., Marietta (29-GP—Assoc)
 Pepin, Henry S., Thomasville (65-GP)
 Perdue, Garland D., Jr., Emory University (29-S—Assoc)
 Perkins, George E., II, Rome (27-Pul)
 Perkins, H. R., Augusta (54-OALR)
 Perkinson, W. H., Marietta (17-GP)
 Perrow, G. H., Jasper (14-GP)
 Perry, Robert E., Jr., Chapel Hill, N. C. (56-Path—Assoc)
 Perry, Samuel W., Atlanta (29-Pd)
 Persall, John T., Augusta (54-ObG)
 Person, W. E., Atlanta (29- —Life)
 Peters, James S., Jr., Nashville (56-GP)
 Peters, John H., Atlanta (29-I—Assoc)
 Peters, Margaret P., Atlanta (29-)
 Peterson, T. A., Savannah (11-GP)
 Petrie, Eleanor Byers, Decatur (22-PH)
 Petrie, Lester M., Atlanta (29-PH)
 Pharr, L. P., Auburn (37- —Life)
 Phillips, A. M., Macon (6-Pr)
 Phillips, Curtis M., Jr., New York (54- —Assoc)
 Phillips, Hayward, Augusta (54-Anes)
 Phillips, W. P., LaGrange (68-Ob)
 Philpot, W. K., Augusta (54-GP)
 Phinizy, Irvine, Augusta (54-I)
 Phinizy, John, Lincolnton (78-GP)
 Phinizy, Thomas B., Milledgeville (2-P)
 Phyrdas, Irene, Atlanta (29- —Assoc)
 Pickett, F. B., Ty Ty (66-GP—Life)
 Pierce, L. W., Waycross (72-U)
 Pierotti, Julius V., Atlanta (29-GP)
 Pilcher, George S., Louisville (39-GP)
 Pilcher, John J., Wrens (39-)
 Pilcher, John J., Jr., Wrens (39-GP)
 Pinholster, J. H., Savannah (11-S)

Pinkston, A. G., Jr., Glennville (62-GP)
 Pinson, C. H., Atlanta (29-GP—Life)
 Pinson, Harry D., Augusta (54-S)
 Pirkle, Quentin, Brookhaven (22-S)
 Pittard, M. D., Toccoa (60-GP)
 Pittman, Carl S., Tifton (66-)
 Pittman, Carl S., Jr., Tifton (66-GP)
 Pittman, O. C., Commerce (37-)
 Poer, David Henry, Atlanta (29-S)
 Poliakoff, Samuel R., Atlanta (29-ObG)
 Pomeroy, W. L., Waycross (72-S)
 Pool, Winford H., Jr., Elberton (24-GP)
 Poole, E. T., Lavonia (28-GP)
 Poole, S. O., Gainesville (34-I)
 Pope, Edgar M., Macon (6-ALR)
 Pope, Roy, Jr., Chickamauga (70-GP)
 Porch, Leon D., Macon (6-Or)
 Porter, J. E., Savannah (11-S)
 Porter, J. L., Rutledge (49- —Life)
 Porth, Edna S., Atlanta (29-GP)
 Portman, H. J., Savannah (11-Pd)
 Pou, Leo H., Jr., Augusta (54-Anes)
 Pound, William E., Macon (6-GP)
 Powell, B. C., Villa Rica (10- —Life)
 Powell, C. E., Swainsboro (25-)
 Powell, F. C., Decatur (22-I)
 Powell, Jack H., Jr., Newnan (20-S)
 Powell, John E., Villa Rica (10-GP)
 Powell, John E., Jr., Villa Rica (10-GP)
 Powell, Vernon E., Atlanta (29-I)
 Powers, Leander K., Savannah (11-GP)
 Prather, Stuart H., Jr., Augusta (54-R)
 Prescott, Eustace H., LaGrange (68-PH)
 Primrose, A. C., Americus (61-GP)
 Prince, Charles L., Savannah (11-U)
 Pritchett, D. W., Barnesville (41-OALR)
 Pritchett, J. H., Jr., Monticello (38-GP)
 Pritchett, John Henry, Jr., Bremen (10-)
 Pruce, Arthur M., Atlanta (29-PM)
 Pruce, Martha, Durham, N. C. (29-P—Assoc)
 Pruitt, Marion C., Atlanta (29-Pr)
 Pruitt, Maurice C., Chattanooga, Tennessee (70-)
 Pryor, Carol G., Augusta (54-ObG)
 Puckett, Hollis E., Savannah (11-GP)
 Puett, W. W., Norcross (13-GP)
 Pugh, C. M., Lumpkin (53-)
 Pumpelly, Robert A., Jesup (75-GP)
 Pund, Edgar R., Augusta (54-Path)
 Purcell, Bill, Calhoun (31-GP)
 Pursley, N. B., Gracewood (2-)

Q

Quattlebaum, J. K., Savannah (11-S)
 Quattlebaum, Robert B., Augusta (58-GP)
 Quillian, B. O., Douglas (18-GP—Life)
 Quillian, W. B., Jr., Cartersville (4-GP)
 Quillian, W. Earl, Atlanta (29-S—Life)
 Quinn, David E., Dublin (24- —Assoc)

R

Rabb, J. L., Calhoun (31-GP)
 Rabhan, Leonard J., Savannah (11-Pr)
 Rabun, J. B., Savannah (11-R)
 Ragan, W. E., Jr., Atlanta (29- —Life)
 Raiford, Morgan B., Atlanta (29-Oph)
 Randolph, R. H., Athens (15-S)
 Randolph, W. T., Winder (37-GP)
 Randolph, W. Quenton, Winder (37-GP—Assoc)
 Rankin, Joseph L., Atlanta (29-D)
 Rankine, C. A. N., Brookhaven (29-GP)
 Raper, Hal Stuart, Warm Springs (45-)
 Rasmussen, Earl, Atlanta (29-S)
 Rauber, Albert Paul, Atlanta (29-Pd)
 Rawiszer, Hubert, Atlanta (29-I)
 Rawlings, William, Sandersville (74-)
 Rawls, Lewis L., Macon (6-GP)
 Rawls, Otis Grey, Albany (23-S)
 Rayle, A. A., Sr., Atlanta (29-R)
 Rayle, Albert A., Jr., Atlanta (29-R)
 Read, Ben S., Atlanta (29-G)

Read, Joseph C., Atlanta (29-S)
 Readling, Herbert F., Thomasville (65-GP)
 Reavis, W. F., Waycross (72-U)
 Redd, Bryan L., Jr., Emory University (29-R)
 Redd, Stephen C., Atlanta (29-Pd)
 Redfearn, J. A., Albany (23-I-Life)
 Redmond, C. G., Savannah (11- —Life)
 Redmond, C. R. A., Savannah (11-)
 Reed, John H., Jr., Gainesville (34-Oph)
 Reese, D. S., Carrollton (10-OALR—Life)
 Reeve, Thomas E., Jr., Carrollton (10-S)
 Reeves, Nathan, Augusta (54-I)
 Reeves, Ninette, Augusta (54-P)
 Reeves, Walton H., Boston, Massachusetts (29-I—Assoc)
 Reichel, Hans A., Savannah (11-)
 Reid, J. W., Thomasville (65-GP)
 Reid, William Archer, Atlanta (29-S—Assoc)
 Reid, William G., Columbus (47-I—Sci)
 Reifler, R. M., Macon (6-D)
 Reilly, Enos J., Augusta (54-ObG)
 Reisman, Edward D., Atlanta (29-S)
 Reith, Paul L., Warm Springs (29-Or)
 Rentz, Turner W., Colquitt (58-)
 Retterbush, W. C., Valdosta (56-S)
 Revell, Walter J., Louisville (39-)
 Rey, Charles J., Jr., Atlanta (29-S—Assoc)
 Reynaud, L. F., Atlanta (29-Pd)
 Reynaud, Virginia G., Atlanta (29-Pd)
 Reynolds, A. B., Cairo (32-)
 Reynolds, J. S., Atlanta (29-GP)
 Rhea, James W., Columbus (47-Pd)
 Rhodes, C. A., Atlanta (29-GP—Life)
 Rhodes, R. L., Augusta (54-S—Life)
 Rhyne, Walter P., Albany (23-OALR)
 Rice, Guy V., Atlanta (29-PH)
 Rice, Keith C., Atlanta (29-S)
 Richards, Charles K., Calhoun (31-GP)
 Richardson, A. C., Jr., Atlanta (29-ObG)
 Richardson, C. H., Jr., Macon (6-S)
 Richardson, Charles H., Macon (6-S)
 Richardson, Jeff L., Atlanta (29-I)
 Richardson, R. C., Albany (23-OALR)
 Richardson, R. W., Macon (6-OALR)
 Richardson, Sterling H., Atlanta (29-S)
 Richmond, Lea, Atlanta (29-S)
 Ridgway, Robert E., Royston (28-GP)
 Ridley, C. L., Jr., Macon (6-S)
 Ridley, C. L., Sr., Macon (6-GP—Life)
 Ridley, Harry W., Atlanta (29-GP)
 Ridley, John H., Atlanta (29-G)
 Rieser, Charles, Atlanta (29-U)
 Righton, H. Y., Savannah (11-U—Life)
 Riley, B. F., Jr., Thomson (44-GP—Life)
 Rinker, J. Robert, Augusta (54-U)
 Risteen, W. A., Augusta (54-NS—Assoc)
 Rivers, Jane A., Columbus (47-Pd)
 Rivers, W. P., Jr., Columbus (47-Pd)
 Roach, George S., Jr., Atlanta (29-ALR)
 Robbins, Allen I., Homerville (56-)
 Robbins, John H., Athens (15-PH)
 Roberson, Phil E., Albany (23-ObG)
 Roberts, B. J., Cornelia (33-I)
 Roberts, C. Purcell, Atlanta (29-I)
 Roberts, J. A., Alpharetta (29-Oph)
 Roberts, Jessie Morris, Alpharetta (29- —Assoc)
 Roberts, Luther J., Columbus (47-S)
 Roberts, M. H., Atlanta (29-Pd)
 Roberts, O. W., Carrollton (10- —Life)
 Roberts, Ralph D., Fitzgerald (5-GP)
 Roberts, Robert Eugene, San Francisco, California (29-I—Assoc)
 Roberts, S. M., Augusta (54-R—Assoc)
 Robertson, J. R., Augusta (54-U—Life)

Robinson, David, Savannah (11-R)
 Robinson, Joe S., Rome (29-S)
 Robinson, John H., III, Americus (61-S)
 Robinson, Ralph L., Atlanta (29-Pd)
 Robinson, Robert L., Atlanta (29-GP)
 Robinson, Robert S., Vienna (26-GP)
 Robison, William P., Augusta (54-P)
 Roche, William Patrick, Jr., Dublin (42-I)
 Roddenberry, S. A., Columbus (47-S)
 Rogers, A. A., Commerce (37-GP)
 Rogers, A. A., Jr., Commerce (37-GP)
 Rogers, F. S., Coleman (53-GP—Assoc)
 Rogers, J. Harry, Atlanta (29-S)
 Rogers, J. V., Jr., Emory University (29-R)
 Rogers, J. V., Sr., Cairo (32-GP)
 Rogers, O. L., Sandersville (74—Life)
 Rogers, R. L., Gainesville (34-S)
 Rogers, T. E., Macon (6-ObG—Assoc)
 Rogers, T. E., Jr., Macon (6-ObG)
 Roles, C. L., Camilla (46—)
 Rollings, Harry E., Savannah (11-I)
 Rollins, J. C., College Park (76—Life)
 Rollins, Luther C., Jr., Atlanta (29-S—Assoc)
 Romeo, C. J., Dublin (42—Assoc)
 Roper, C. J., Jasper (14-S)
 Roper, E. A., Jasper (14-GP)
 Rosen, E. A., Dalton (76-GP)
 Rosen, E. F., Savannah (11-OALR)
 Rosen, Samuel F., Savannah (11-D)
 Rosenberg, Albert A., Atlanta (29-Pd)
 Rosenberg, H. J., Atlanta (29-GP)
 Ross, Grace R., Cedartown (51-GP)
 Ross, Ivan B., Atlanta (29-Path)
 Ross, Thomas L., Macon (6-I)
 Rouglin, L. C., Atlanta (29-OALR—Assoc)
 Roule, J. Victor, Augusta (54-OALR)
 Rowland, J. Roy, Jr., Dublin (42-GP)
 Rubin, Jacob, Savannah (11-I)
 Rubin, Samuel N., Gordon (6-Pd)
 Rucker, J. T., Jr., Augusta (54-Anes)
 Rudder, Fred F., Atlanta (29-S)
 Rumble, Charles T., Macon (6-Pd)
 Rumble, Lester, Jr., Atlanta (29-Anes)
 Rushia, E. L., Augusta (54-Anes)
 Rushin, C. E., Atlanta (29-S)
 Russell, Alexander B., Winder (37—)
 Russell, David A., Jr., Atlanta (29-GP)
 Russell, E. K., Atlanta (29-I)
 Russell, Paul T., Albany (23-GP)
 Rutland, S. C., Atlanta (6-PH)

S

Sage, Dan Y., Atlanta (29—Life)
 St. John, J. O., Newnan (20-GP)
 Salter, W. L., Savannah (11-GP)
 Samra, Jose Antonio, Hapeville (29-GP—Assoc)
 Sams, Ferrol A., Jr., Fayetteville (16-GP)
 Sams, Frank H., Reynolds (63-GP)
 Sams, Helen F., Fayetteville (16-GP)
 Sams, Henry L., Dalton (76—Life)
 Sams, J. R., Covington (48-GP)
 Sams, William C., Jr., Ocilla (5-GP)
 Sanchez, A. S., Eatonton (2-GP)
 Sanchez, S. E., Jr., Barwick (65—)
 Sanders, Floyd R., Decatur (22-GP)
 Sandison, J. Calvin, Atlanta (29-Or)
 Santana, Henry, Atlanta (29-Path—Assoc)
 Sapp, Clarence J., Rome (27-S)
 Sappington, T. A., Thomaston (69-GP)
 Saunders, A. F., Valdosta (56-ObG)
 Savage, C. P., Montezuma (61-GP)
 Sax, Charles E., Savannah (11-ObG)
 Saye, E. B., Thomasville (65-Path)
 Scarborough, J. E., Emory University (29-S)

Scardino, Peter L., Savannah (11-U)
 Schaefer, W. B., Toccoa (60-S)
 Scharnitzky, E. O., Augusta (54-I)
 Scheinbaum, C. N., Atlanta (29-GP)
 Schellack, J. K., Atlanta (29-S)
 Schenck, H. C., Atlanta (29-I)
 Schley, Frank B., Columbus (47-Pd)
 Schley, Richard L., Jr., Savannah (11-Pd)
 Schmidt, Don, Cedartown (51-GP)
 Schmidt, F. K., Marietta (17-U)
 Schneider, J. F., Atlanta (29-GP)
 Schneider, M. M., Savannah (11-ObG)
 Schneider, W. J., Folkston (72—)
 Schreeder, John M., Chamblee (22—)
 Schroder, J. Spalding, Emory University (29-I)
 Schroeder, Paul L., Atlanta (29-P)
 Schuessler, George, Columbus (47-GP)
 Schwartz, Larry A., Macon (6-Pd)
 Scoggins, P. T., Commerce (37-GP)
 Scott, Legh R., Jr., Atlanta (29-I)
 Scott, Mildred E., Atlanta (29-PH)
 Scott, Morgan, Thomaston (69—)
 Scott, Thomas P., Jr., Sheffield, England (29-Pd—Assoc)
 Scott, Wilbur M., Milledgeville (2-S)
 Sealey, Romero Mitchell, Atlanta (29-ObG)
 Sealy, Hugh K., Macon (6-I)
 Seaman, H., Ansley, Waycross (72-GP)
 Sears, Robert A., Atlanta (29-NS)
 Seay, E. Faxton, Marshallville (61—)
 Sell, M. B., Jr., Augusta (54-GP)
 Sellers, T. F., Atlanta (29-PH)
 Sellers, Thomas F., Jr., Atlanta (29-I—Assoc)
 Selman, W. A., Atlanta (29-S)
 Serrato, J. C., Houston, Texas (47-Or)
 Sewell, W. A., Rome (27—Life)
 Seymour, Glenn E., Albany (23-S)
 Shackelford, B. L., Atlanta (29-S)
 Shanks, Edgar D., Jr., Atlanta (29-I)
 Sharp, C. K., Arlington (58-GP)
 Sharpe, W. W., III, Alma (72-GP)
 Sharpley, H. F., Jr., Savannah (11-ObG)
 Sharpley, Helen, Savannah (11-Ob)
 Sharpley, John G., Savannah (11-S)
 Shea, P. C., Jr., Atlanta (29-S)
 Shealy, L. M., Quitman (65-GP)
 Shearouse, J. William, Savannah (11—)
 Sheldon, Walter H., Emory University (29-Path)
 Shellhouse, L. A., Willacoochee (18-GP—Life)
 Shepard, Duncan, Atlanta (29-S)
 Shepard, J. L., Omega (66-GP)
 Shepard, Kirk, Thomasville (65-S)
 Shepard, Richard C., Jr., LaFayette (70-GP)
 Shepard, W. O., Bluffton (58-GP)
 Sheppard, Walter L., Augusta (54-Path)
 Shepherd, Edwin C., New York, N. Y. (11-Pd—Assoc)
 Shepherd, Mason H., Augusta (54-S—Assoc)
 Sherman, Henry T., Valdosta (56-I)
 Sherman, J. H., Augusta (54-S)
 Shessel, Herbert L., Atlanta (29-ObG)
 Shields, H. F., Chickamauga (70-GP—Life)
 Shiflet, Robert E., Toccoa (60-GP)
 Shinall, Robert P., Decatur (22-GP)
 Shipp, C. C., Thomasville (65-OALR)
 Shirley, William C., Macon (6-ObG)
 Shiver, Charles B., Augusta (54—Assoc)
 Shivers, Olin G., Atlanta (29-Pd)
 Shuman, Vilda, Waycross (72-Pd)
 Siegel, Alvin E., Macon (6-I)
 Sigman, Cheney C., Jr., Forest Park (29-Pd)
 Sikes, Z. S., Dublin (42—Assoc)

Silver, D. M., Augusta (54—)
 Silverstein, Charles M., Atlanta (29-R)
 Simmons, J. W., Brunswick (30—Life)
 Simmons, M. Freeman, Decatur (22-GP)
 Simmons, Mack, St. Simons Is. (50-S)
 Simmons, W. E., Metter (8-I)
 Simmons, William G., Sylvania (55-GP)
 Simonton, Fred H., Chickamauga (70-GP)
 Simpson, A. W., Washington (78-GP—Life)
 Simpson, A. W., Jr., Washington (78—)
 Simpson, John A., Athens (15-Pd)
 Sims, A. R., Richland (53—)
 Sims, Fayette A., Jr., Lawrenceville (13—)
 Sims, Fred E., Dawson (53—)
 Sims, J. P., Ft. Oglethorpe (70—)
 Sims, Marshall R., Atlanta (29-Pd—Life)
 Sims, Stewart Eugene, Atlanta (29-S)
 Singer, Arthur G., Toccoa (60-R)
 Singer, S. B., Jr., Dublin (42—Assoc)
 Singleton, C. K., Cairo (32—)
 Singleton, Donald W., Atlanta (29-S—Assoc)
 Sinkoe, S. J., Atlanta (29-U)
 Sirmons, D. C., Dahlonega (34-GP)
 Skelton, C. B., Winder (37-GP)
 Skiles, William Vernon, Atlanta (29-ObG)
 Skinner, James M., Augusta (54—Assoc)
 Skipper, William Groover, Atlanta (29-S)
 Skobba, Joseph S., Atlanta (29-P)
 Slade, Helen Benedict, Atlanta (29-Pd—Assoc)
 Slade, John deR., Atlanta (29-I)
 Sloan, W. P., Atlanta (29-I)
 Sloan, W. P., Jr., Atlanta (29-I)
 Smaha, T. G., Griffin (59-G)
 Smith, A. C., Elberton (24—Life)
 Smith, Arthur A., Atlanta (29-ObG)
 Smith, C. C., Augusta (54-D)
 Smith, Carl L., Cairo (32-GP)
 Smith, Carter, Atlanta (29-I)
 Smith, Charles M., Rockmart (51-GP)
 Smith, Charles R., Columbus (47-P)
 Smith, Charles W., Atlanta (29-ObG)
 Smith, E. G., Jr., Atlanta (29-R)
 Smith, E. J., Hahira (56-GP—Life)
 Smith, F. A., Elberton (24—)
 Smith, F. A., Jr., McRae (64-GP)
 Smith, Fred C., Valdosta (56-S)
 Smith, G. B., Rome (27-Oph—Life)
 Smith, H. A., Americus (61—)
 Smith, H. M., Savannah (11-GP)
 Smith, H. W., Swainsboro (25-Ob)
 Smith, Inman, Rome (27-Pd)
 Smith, J. Allen, Macon (6-OALR)
 Smith, J. E., Fitzgerald (5-GP)
 Smith, J. Gregg, Valdosta (56-PH)
 Smith, J. R., Hahira (56-GP)
 Smith, J. Walter, Milledgeville (2-N)
 Smith, James W., Manchester (45-GP)
 Smith, Joel P., Atlanta (29-OALR)
 Smith, L. A., Quitman (65-S)
 Smith, Leo, Waycross (72-OALR)
 Smith, Linton, Atlanta (29—Life)
 Smith, Lucius S., Rome (27-R)
 Smith, Martin H., Gainesville (34-Pd)
 Smith, Melvin E., Milledgeville (2-P)
 Smith, P. H., Savannah (11-ObG)
 Smith, R. L., Cochran (50-GP)
 Smith, R. S., Macon (6-GP)
 Smith, Randolph, Atlanta (29-Or)
 Smith, Reuben E., Lawrenceville (13—Assoc)
 Smith, Samuel R., Milledgeville (2-GP)
 Smith, Stephen D., Rome (27-Pd)
 Smith, T. H., Valdosta (56-OALR—Life)

Smith, W. P., Bowdon (10-GP—Life)
 Smith, W. P., Decatur (22-I)
 Smith, William A., Atlanta (29-N)
 Smoot, Richard H., Decatur (22-S)
 Snelling, W. R., Columbus (47-S)
 Somers, William H., Macon (6-)
 Sotolongo, Eladio, Atlanta (29-Anes)
 Spanjer, Raymond F., Cedartown (51-GP)
 Spier, Eugene, Atlanta (29-Anes)
 Spitzer, I. Q., Chamblee (22-GP)
 Spitznagle, V. E., Salisbury, Maryland (21-PH)
 Spivey, Lee Myrl, Charleston, S. C. (29—Assoc)
 Spivey, Oscar S., Macon (6-Pd)
 Stalvey, J. K., Jr., Savannah (11-S)
 Stamps, Edward Roe, Macon (6-U)
 Stanford, J. W., Cartersville (4-GP)
 Standifer, J. G., Blakely (58-)
 Stapleton, C. E., Statesboro (8-GP)
 Stapleton, James W., Dublin (42-Or—Assoc)
 Stapleton, John L., Columbus (47-U)
 Stapleton, Tommy K., Pearson (18-GP)
 Starr, Harlan M., Rome (27-Pd)
 Starr, Trammell, Dalton (76-GP)
 Statham, George W., Decatur (22-Pd)
 Steadman, Henry E., Hapeville (29-ObG)
 Steed, William A., Augusta (54-OALR)
 Steele, Byron Harold, Fairmount (31-GP)
 Steele, Virgil S., Eastman (50-OALR)
 Stegall, Robert E., Moultrie (19-S)
 Stegeman, John F., Athens (15-I)
 Stelling, Henry G., Atlanta (29-)
 Stenhouse, Henry M., Jr., Atlanta (29-R)
 Stephens, A. Leslie, Jr., Atlanta (29-ObG)
 Stephens, Robert G., Washington (78-GP—Life)
 Stephenson, Charles W., Ringgold (70-GP)
 Stephenson, Evelyn M., Rome (27-Path)
 Stephenson, Robert H., Atlanta (29-S)
 Stevenson, C. A., Camilla (46- —Life)
 Stevenson, Gilbert M., Augusta (54-I)
 Stewart, Calvin B., Atlanta (29-S)
 Stewart, Charles Calloway, Patuxent River, Maryland (29- —Assoc)
 Stewart, J. Benham, Macon (6-S)
 Stewart, Philip R., Monroe (71-S)
 Stewart, Thomas W., Lithonia (22-GP)
 Stillerman, H. B., Atlanta (29-I)
 Stillwell, John D., Thomasville (65-PH)
 Stinson, F. F., Jr., Thomasville (65-U)
 Stokes, Joseph Jack, Atlanta (29-Oph)
 Stone, Charles F., Atlanta (29-I)
 Stone, J. C., Doerun (19- —Life)
 Stone, R. L., Savannah (11-Anes)
 Stoner, Cyrus H., Atlanta (29-Oph)
 Stoner, W. P., Sylvester (79-GP)
 Storey, W. E., Columbus (47-I)
 Stovall, J. T., Jefferson (37-GP)
 Straight, George W., Savannah (11-)
 Strickland, L. V., Cobbtown (62-GP)
 Strickler, C. W., Jr., Atlanta (29-I)
 Stroup, David G., Atlanta (29-ObG)
 Stuckey, Ann D., Griffin (59-Pd)
 Stump, Robert L., Jr., Valdosta (56-GP)
 Styles, O. R., Cedartown (51-)
 Suarez, Raymond, Macon (6-GP)
 Sullivan, Cary E., Atlanta (29-Pd)
 Sullivan, Daniel B., Augusta (54-S—Assoc)
 Summerour, Brooke F., Dalton (76-Anes)
 Sutterfield, Gerald R., Atlanta (29-ObG)
 Sutton, James Mack, Jr., Albany (23-Pd)
 Swann, W. K., Covington (48-)
 Swanson, Cosby, Atlanta (29- —Life)
 Swanson, Homer, Atlanta (29-NS)

Swift, J. S., Atlanta (29-Or)
 Swilling, Evelyn, Macon (6-Ob)
 Swint, Robert H., Statesboro (8-S)
 Sydenstricker, V. P., Augusta (54-I)
 Sylvester, Hart, Hawkinsville (50-)
T
 Tabb, William Granville, Jr., Atlanta (29-Oph)
 Talbert, William G., Jr., Warner Robins (36-GP)
 Talmadge, Harry E., Athens (15-S)
 Talmadge, Sam M., Athens (15-S)
 Tankesley, Robert M., Atlanta (29-R)
 Tanner, David E., Augusta (54-R—Assoc)
 Tanner, James C., Jr., Atlanta (29-S)
 Tanner, W. H., Newnan (20-GP—Life)
 Tanner, William F., Young Harris (7-GP)
 Taranto, Morris B., Atlanta (29-GP)
 Tarplee, Scott L., Atlanta (29-I)
 Tate, John Drewry, Rome (27-GP)
 Taylor, Clayton D., Columbus (47-D)
 Taylor, John Edwin, Jr., Decatur (22-Pd)
 Taylor, John L., Franklin (68-GP—Life)
 Taylor, L. B., Savannah (11- —Life)
 Taylor, Ralph, Davisboro (74-GP)
 Taylor, Thomas B., Douglasville (10-)
 Taylor, Warren A., Thomasville (65-S)
 Taylor, William J., Atlanta (29-GP)
 Teal, C. B., Ellijay (7-GP)
 Teate, H. Luten, Jr., Atlanta (29-Pd)
 Teem, M. V. B., Marietta (17-I)
 Templeton, C. M., Augusta (54-GP)
 Teplis, Paul, Atlanta (29-I)
 Terrell, Warren, Ft. Oglethorpe (70-GP)
 Terry, D. B., Homerville (72-GP)
 Tessier, Claude E., Augusta (54-Pd)
 Thebaut, Ben R., Atlanta (29-S)
 Thigpen, Corbett H., Augusta (54-P)
 Thomas, David R., Jr., Augusta (54-I)
 Thomas, Frank E., Albany (23-Pd)
 Thomas, Frank H., Valdosta (56-Pr—Life)
 Thomas, James R., Griffin (59-GP)
 Thomas, N. R., Albany (23-ObG—Life)
 Thomas, Russell, Americus (61-)
 Thomas, Wesley C., Brunswick (30-OALR)
 Thomason, C. Griggs, East Point (29-GP)
 Thomason, W. L., Atlanta (29-S)
 Thomasson, W. E., Carrollton (10-)
 Thompson, C., Jr., Waynesboro (9-GP)
 Thompson, Cleveland, Waynesboro (9-S—Life)
 Thompson, D. N., Elberton (24-GP—Life)
 Thompson, D. O., Atlanta (29-GP)
 Thompson, E. F., Valdosta (56-OALR)
 Thompson, Emory F., Valdosta (56-OALR)
 Thompson, Ernest, Monroe (71-PH)
 Thompson, F. H., Albany (23-Path)
 Thompson, John B., Jr., Columbus (47-OALR)
 Thompson, John W., Atlanta (29-Pd)
 Thompson, O. R., Macon (6-ObG)
 Thompson, R. H., Brunswick (30-GP)
 Thompson, William R., Atlanta (29-ObG)
 Thomson, James L., Darien (30-GP)
 Thornton, H. A., Greensboro (49-GP)
 Thornton, Lawson, Atlanta (29-Or)
 Thoroughman, J. C., Atlanta (29-S)
 Thrash, J. A., Columbus (47-PH)
 Threatte, Bruce, Columbus (47-S)
 Thurmond, A. G., Augusta (54-ObG)
 Thurmond, J. W., Augusta (54-ObG)
 Thurston, J. A., Dublin (42-S—Assoc)
 Tidmore, T. L., Atlanta (29-Anes)
 Tift, Henry H., Macon (6-I)

Tillery, Bert, Columbus (47-S)
 Timberlake, G. B., Atlanta (29-S)
 Timberlake, Lloyd F., Atlanta (29-I)
 Titshaw, H. S., Gainesville (34-)
 Titus, Norman E., Savannah (11-PM)
 Todd, Charles E., Jr., Atlanta (29-S)
 Toker, Donald Lee, Boston, Massachusetts (29-PH—Assoc)
 Tolhurst, George M., Cleveland (33-GP—Assoc)
 Tootle, George S., Atlanta (29-S)
 Torpin, Richard, Augusta (54-ObG)
 Townsend, E. M., Ringgold (70- —Life)
 Towson, Ira G., Sea Island (30-GP)
 Tracy, J. L., Jr., Sylvester (79-GP)
 Train, John Kirk, Jr., Savannah (11-ALR)
 Traylor, James Bothwell, Athens (15-ObG)
 Traylor, S. B., Barnesville (41-)
 Treusch, H. L., Atlanta (29-I—Assoc)
 Trimble, W. H., Atlanta (29-I)
 Trotter, John F., Decatur (22-GP)
 Truelock, Albert S., Jr., Albany (23-S)
 Tuck, G. G., Covington (48-GP)
 Tucker, John P., Moultrie (21-GP)
 Tucker, R. P., East Point (29-S)
 Tuggle, M. Virginia, Decatur (22-I)
 Tumlin, Paul F., Atlanta (29- —Assoc)
 Turk, L. N., Jr., Atlanta (29-S)
 Turner, August B., Atlanta (29-S)
 Turner, Edwin W., Norway (29- —Assoc)
 Turner, H. H., Columbus (47-I—Assoc)
 Turner, J. D., Nashville (56-GP)
 Turner, J. R., LaGrange (68-)
 Turner, John W., Atlanta (29-S)
 Turner, W. W., Nashville (56-GP)
 Turrentine, Paul E., Atlanta (29-ObG)
 Tye, J. P., Albany (23-S)
 Tyler, Herbert D., Thomaston (69-I)
U
 Upchurch, W. E., Atlanta (29-U)
 Upshaw, C. B., Atlanta (29-ObG)
 Upton, E. T., Savannah (11-S)
 Usher, Charles, Savannah (11-S—Life)
V
 Valente, L. A., Brunswick (30-S)
 Valentine, H. E., Jr., Gainesville (34-I)
 Van Buren, E., Atlanta (29-I)
 Van Fleit, William E., Emory University (29-S)
 Vansant, C. V., Douglasville (10-GP)
 Vansant, Claude V., Jr., Douglasville (10-GP)
 Vansant, J. I., Villa Rica (10-GP)
 Vansant, T. J., Woodstock (14-GP—Life)
 Vansant, T. J., Jr., Marietta (17-I)
 Varner, John B., Atlanta (29-ObG)
 Varner, W. D., Columbus (47-ObG)
 Vassey, G. C., Rossville (70-GP)
 Vaughan, R. H., Columbus (47-S)
 Veal, Curtis F., Milledgeville (2-GP)
 Veatch, J. W., Jr., Atlanta (29-S)
 Velkoff, Abraham S., Atlanta (29-ObG)
 Venable, John, Atlanta (29-PH)
 Verner, J. C., Commerce (37-GP)
 Victor, Irving, Savannah (11-U)
 Victor, Jules, Jr., Savannah (11-I)
 Victor, Samuel, Waycross (72-GP)
 Vincenzi, Rosina, Atlanta (29-Path)
 Vinson, C. D., Atlanta (29-GP—Life)
 Vinson, Frank, Fort Valley (6-GP)
 Vinson, T. O., Decatur (22-PH)
 Virusky, E. J., Baxley (1-S)
 Visanska, S. A., Atlanta (29- —Life)
 Volpito, P. P., Augusta (54-Anes)
 Vonderlehr, R. A., Atlanta (29- —Assoc)
 Voyles, Walter R., Augusta (54- —Assoc)

W

Wade, V. C., Valdosta (56-)
Wagnon, George N., Reno, Nevada (29-
—Assoc)
Wahl, Ernest F., Thomasville (65-I)
Wailes, S. L., Covington (48-GP)
Waits, Edward Jones, Atlanta (29-PH—
Assoc)
Waldemayer, E. W., Americus (61-GP)
Waldrep, Jack Marion, Rome (27-U)
Walker, D. D., Macon (6-G)
Walker, Duncan, Jr., Macon (6-ALR)
Walker, E. Y., Milledgeville (2-ObG)
Walker, Edwin M., South Bend, Indiana
46-GP)
Walker, Exum, Atlanta (29-NS)
Walker, George L., Griffin (59-I)
Walker, J. Frank, Atlanta (29-R)
Walker, J. L., Clarksville (33-GP)
Walker, John E., Columbus (47-I)
Walker, John R., Atlanta (29-S)
Walker, John S., Atlanta (29-Pd)
Walker, Mary E., Decatur (22-Pd)
Walker, W. A., Cairo (32-GP—Assoc)
Walker, William W., III, Atlanta (29-
—Assoc)
Wall, Bithel, Augusta (34-U)
Wall, C. K., Thomasville (65-S)
Wall, Hilton F., Atlanta (29-S)
Wall, Margaret J., Atlanta (29-I)
Wallace, J. W., Douglas (18-I)
Wallace, Warren S., Brunswick (30-GP)
Waller, Roy M., Jr., Columbus (47-GP)
Wallis, J. R., Lovejoy (16- —Life-Dec)
Walter, Austin J., Sautee (33-GP)
Walter, R. D., Calhoun (31-GP)
Wammock, Hoke, Augusta (54-S)
Wammock, Virgene S., Augusta (54-D)
Ward, Emmett, Atlanta (29-)
Ward, Eugene L., Gainesville (34-OALR)
Ward, Francis O., Fitzgerald (5-GP)
Ward, George A., Elberton (24- —
Life)
Ward, James, Columbus (47-ObG)
Ward, John A., Monticello, Florida (53-
GP)
Ward, John Albin, Atlanta (29- —
Assoc)
Ward, William C., Atlanta (29-S)
Warga, P. W., Athens (15-Path)
Waring, A. J., Jr., Savannah (11-Pd)
Waring, Ruth M., Savannah (11-Or)
Waring, Thomas P., Savannah (11-Or)
Warkentin, John, Atlanta (29-P)
Warnell, J. B., Cairo (32-GP—Assoc)
Warner, William Philip, Jr., Atlanta (29-
Or)
Warnock, C. M., Atlanta (29-GP)
Warren, W. C., Jr., Atlanta (29-ALR)
Wasden, Charles N., Macon (6-S)
Wasden, Harry A., Quitman (65-S)
Wasden, Howell A., Jr., Pavo (65-GP)
Waters, A. J., Augusta (54-Anes)
Waters, W. C., Jr., Atlanta (29-I)
Watkins, Charles B., Ellijay (14-GP)
Watkins, E. W., Ellijay (7- —Life)
Watkins, W. M., Dublin (42-S)
Watson, Edwin R., Macon (6-Pd)
Watson, W. G., Augusta (54-ObG)
Watt, C. H., Thomasville (65-S)
Watt, Charles H., Jr., Thomasville (65-
S)
Watters, Julian Q., Atlanta (29-Pd)
Watts, J. W., Bowdon (10-GP)
Weaver, H. G., Macon (6-S)
Weaver, J. Calvin, Atlanta (29-GP—
Life)
Weddington, W. H., Marietta (17-)
Weeks, J. L., Harlem (54- —Assoc)
Weeks, Richard B., Augusta (54-S)
Weems, H. E., Jr., Perry (6-GP)

Weens, H. S., Atlanta (29-R)
Wehs, Richard J., Augusta (54-Ind)
Weinberg, James I., Atlanta (29-I)
Weinberg, Seymour Paul, Atlanta (29-
ObG)
Weinstein, A. A., Atlanta (29-S)
Weitz, Frank, Atlanta (29-Pd)
Welch, C. B., Attapulugus (21-Oph)
Wells, David A., Dalton (76-GP)
Wells, John G., Newnan (20-I)
Wells, Robert E., Atlanta (29-)
Welter, J. A., Dublin (42- —Assoc)
Wenzel, R. E., Social Circle (71-)
West, C. M., Atlanta (29-I)
West, Edward M., Atlanta (29-I)
Westerfield, C. W., Savannah (11-Anes)
Westfall, Paul P., Dawsonville (7-GP)
Whately, E. C., Reynolds (63-)
Whately, Lewis R., Cartersville (4-GP)
Wheat, R. F., Bainbridge (21-GP—Life)
Wheeler, Stanley D., Loma Linda, Cali-
fornia (70- —Assoc)
Whelchel, A. J., Cordele (26- —Life)
Whelchel, C. D., Gainesville (34-)
Whelchel, G. O., Athens (15-GP)
Whelchel, Merritt C., Augusta (54-Oph)
Whipple, Robert L., Jr., Atlanta (29-I)
Whitaker, Carl A., Atlanta (29-P)
Whitaker, William G., Jr., Atlanta (29-
S)
White, C. A., Jr., Augusta (54-S)
White, Edward Olin, Madison (49-GP)
White, George M., Rockmart (51-)
White, W. O., Augusta (54-Oph)
Whitehead, C. Mark, LaGrange (68-U)
Whiteman, Harold, Jonesboro (16-GP)
Whiteside, J. H., Statesboro (8-S)
Whitfield, T. W., Dalton (76-GP)
Whitley, James R., Winder (37-GP)
Whitley, L. L., Athens (15-GP)
Whittendale, W. H., Norman Park (19-
—Life)
Whitworth, C. W., Gainesville (34-
GALR)
Wilcox, Everard A., Beaufort, S. C. (54-
—Life)
Wilkes, W. A., Augusta (54-Pd)
Wilkins, S. A., Jr., Emory University
(29-S)
Wilcox, W. D., Fitzgerald (5-GP)
Williams, A. F., Savannah (11-I)
Williams, C. O., West Point (68-GP—
Life)
Williams, Charles Roy, Wadley (39-GP)
Williams, David C., Jr., Augusta (54-U)
Williams, David C., Sr., Milledgeville
(2-P)
Williams, George A., Atlanta (29-ObG)
Williams, H. J., Cordele (26-OALR)
Williams, Howard J., Macon (6-Pd)
Williams, J. S., Macon (6-)
Williams, John W., Jr., Lavonia (28-GP)
Williams, L. A., Ringgold (70-GP)
Williams, L. E., Cordele (26-GP)
Williams, L. W., Savannah (11-S)
Williams, M. W., Camilla (46-GP)
Williams, P. L., Cordele (26-GP)
Williams, P. L., Jr., Cordele (26- —
Assoc)
Williams, Ralph Chester, Atlanta (29-PH
—Assoc)
Williams, T. C., Valdosta (56-GP)
Williams, Thomas H., Macon (6-S)
Williams, Virgil B., Griffin (59-S)
Williams, W. A., Macon (6-I)
Williams, W. J., Augusta (54-S)
Willingham, T. I., Atlanta (29-Pd)
Willis, C. H., Jr., Augusta (54- —
Assoc)
Willis, G. W., Ocilla (5-S—Life)
Willis, J. N., Columbus (47-I)
Willis, L. W., Bainbridge (21-GP)
Willoughby, Dan H. (11-I)

Wills, Benjamin C., Savannah (11-P)
Wills, C. E., Sr., Washington (78-GP)
Wills, Charles E., Jr., Washington (78-
GP)
Wills, S. Angier, Atlanta (29-S—Assoc)
Wilmer, John Grant, Atlanta (29-I)
Wilson, C. A., Jr., Brunswick (30-GP)
Wilson, Frank A., III, Leslie (61-GP)
Wilson, Frank Lyndall, Jr., Atlanta (29-
—Assoc)
Wilson, J. S., Atlanta (29-I)
Wilson, John P., Atlanta (29-S)
Wilson, L. E., Bowdon (10- —Life)
Wilson, Paul H., Thomson (44-GP)
Wilson, Richard, Atlanta (29-N)
Wilson, W. D., Savannah (11-S)
Winburn, James R., Jr., Savannah (11-S)
Winchester, M. E., Brunswick (30-PH)
Wine, Mervin B., Thomasville (65-AL)
Winston, R. K., Valdosta (56-Oph)
Wise, B. T., Plains (61-S—Life)
Witham, A. Calhoun, Augusta (54-I)
Withington, John C., Savannah (11-I)
Woddail, Joseph D., Topeka, Kansas
(29- —Assoc)
Wofford, W. E., Cartersville (4-GP)
Wolff, Bernard P., Atlanta (29-I)
Wolff, Luther H., Columbus (47-S)
Wood, D. Lloyd, Dalton (76-GP)
Wood, Frank F., Jr., Albany (23-GP)
Wood, O. S., Washington (78-GP—Life)
Wood, R. Hugh, Emory University (29-I)
Woodall, F. M., Thomaston (69-GP)
Woodall, James A., Thomaston (69-)
Woodall, William Pruitt, Thomaston
(69-)
Woodhall, J. P., Macon (6-S)
Woods, E. Ashby, Bainbridge (21-GP)
Woods, O. C., Milledgeville (2-S)
Woodson, G. C., Jr., Atlanta (29-I)
Woodward, J. G., Dahlonga (34-GP)
Woody, Edgar, Jr., Atlanta (29-I)
Woolley, Lawrence F., Saint Simons Is-
land (30-P)
Woolridge, J. C., Columbus (47- —
Life)
Wooten, L. O., Cordele (26-)
Word, J. J., Milledgeville (2-P)
Work, S. D., Jr., Macon (6-ObG)
Worth, Jack J., Jr., Atlanta (29-S)
Worthy, W. Steve, Carrollton (10-ObG)
Wright, Claude Starr, Augusta (54-I)
Wright, Edward S., Atlanta (29-ALR)
Wright, George W., Augusta (54-S)
Wright, J. T., Atlanta (21-)
Wright, Peter B., Orlando, Florida (54-
Or)
Wyatt, C. J., Jr., Rome (27-I)
Wylie, M. H., Augusta (54-S)
Wynn, O. C., Waycross (72-GP—Sci)

Y

Yampolsky, Joseph, Atlanta (29-Pd)
Yarbrough, J. F., Jr., Augusta (54-Anes)
Yarbrough, Y. H., Milledgeville (2-P—
Life)
Yarn, Charles P., Jr., Atlanta (29-PL)
Yates, A. J., Jr., Soperton (57-GP)
Yeargin, Loyd C., Dalton (76-GP)
Yeomans, James W., Jesup (75-S)
Yeomans, Neal F., Waycross (72-R)
Yochem, August S., Jr., Atlanta (29-P)
York, Jesse H., Atlanta (29-S)
Youles, Owen K., Jr., Valdosta (56-ObG)
Youmans, C. R., Hazlehurst (72-GP)
Youmans, J. R., Columbus (47- —Life)
Youngblood, Samuel, Jr., Savannah (11-
GP)

Z

Zachry, J. D., Gray (6-GP—Life)
Ziimmerman, Charles, Tifton (66-GP)
Zimmerman, W. F., Tifton (66-GP)
Zirkle, John G., Savannah (11-S)

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 Little, Mrs. Robert N., Summerville
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 Anderson, Mrs. Wm. Willis, 63 Avery
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 Wilkins, Mrs. Sam A., Jr., 1196 Springdale Rd., N.E., Atlanta
 Williams, Mrs. George A., 135 Montgomery Ferry Dr., N.E., Atlanta
 Williams, Mrs. R. C., 427 East Wesley Rd., N.E., Atlanta
 Wilson, Mrs. Joseph S., 793 East Morningside Dr., N.E., Atlanta
 Wilson, Mrs. John P., 775 Wilson Rd., N.E., Atlanta

Wilson, Mrs. Richard, 1878 Monroe Dr., N.E., Atlanta
 Wolff, Mrs. Bernard P., 3351 Woodhaven Rd., N.W., Atlanta
 Wood, Mrs. R. Hugh, 900 West Wesley Rd., N.W., Atlanta
 Woodson, Mrs. Grattan C., Jr., 4307 Rickenbacker Way, N.E., Atlanta
 Worth, Mrs. Jack J., Jr., 1434 Miller Ave., N.E., Atlanta
 Wright, Mrs. Edward S., 2865 Howell Mill Rd., N.W., Atlanta
 Yarn, Mrs. Charles P., Jr., 1835 Meredith Dr., N.W., Atlanta

GLYNN COUNTY

Brawner, Mrs. Leon, St. Simons Island
 Britt, Mrs. C. S., St. Simons Island
 Buford, Mrs. Robert S., 1017 Egmont, Brunswick
 Chandler, Mrs. C. B., St. Simons Island
 Collier, Mrs. Thomas W., 706 Gloucester, Brunswick
 Engle, Mrs. Marvin, Darien
 Greer, Mrs. C. B., 1127 Union St., Brunswick
 Hicks, Mrs. James M., 1005 Lanier Boulevard, Brunswick
 Hightower, Mrs. John A., 416 Newcastle, Brunswick
 Inman, Mrs. W. O., Jr., 3021 Parkwood Dr., Brunswick
 Jennings, Mrs. Erwin R., Parkwood Dr., Brunswick
 Johnston, Mrs. T. V., 511 Ellis St., Brunswick
 Mercer, Mrs. Joseph B., 3019 Parkwood Dr., Brunswick
 Mitchell, Mrs. Frank B., Jr., 1407 Palmetto Ave., Brunswick
 Moore, Mrs. Haywood L., 1516 Good-year Ave., Brunswick
 Muse, Mrs. J. Phillip, 2190 Atkinson, Brunswick
 Simmons, Mrs. Mack, St. Simons Island
 Thomas, Mrs. W. C., St. Simons Island
 Thompson, Mrs. Robert H., 2308 Parkwood Dr., Brunswick
 Wallace, Mrs. Warren S., London St., Brunswick
 Wilson, Mrs. Clyde A., Jr., 1203 Lanier Boulevard, Brunswick
 Woolley, Mrs. L. F., Sea Island

GORDON COUNTY

Billings, Mrs. Jordan Eli, 308 North Wall St., Calhoun
 Jackson, Mrs. Gordon W., 412 College St., Calhoun
 Hall, Mrs. Wilbur D., 306 Willard St., Calhoun
 Purcell, Mrs. Bill, 209 Trammell St., Calhoun
 Rabb, Mrs. LeRoy, 305 College St., Calhoun
 Richards, Mrs. Charles K., Victory Dr., Calhoun
 Richards, Mrs. Wm. Roy, Mac Ave., Calhoun
 Steele, Mrs. Byron H., Fairmount
 Walter, Mrs. Robert D., 334 South Wall St., Calhoun

GWINNETT COUNTY

Chastain, Mrs. J. R., Buford
 Hutchins, Mrs. Harry, Buford
 Hutchins, Mrs. W. J., Buford
 Kelley, Mrs. D. C., Lawrenceville
 Martin, Mrs. Dan, Lawrenceville
 Mason, Mrs. Miles H., Duluth
 Puett, Mrs. W. W., Norcross
 Sims, Mrs. Fayette A., Jr., Lawrenceville
 Smith, Mrs. Reuben E., Buford
 Young, Mrs. Robert U., Lawrenceville

HABERSHAM COUNTY

Arrendale, Mrs. Joe J., 505 Level Grove Rd., Cornelia
 Garrison, Mrs. David Harrison, Washington St., Clarkesville
 Garrison, Mrs. Fletcher O., Demorest
 Henry, Mrs. Charles M., Springwood, Clarkesville
 Hicks, Mrs. Loyd Grover, Jr., Laurel Dr., Clarkesville
 Johnson, Mrs. Cecil V., Hiawassee
 Lumsden, Mrs. Thomas N., Helen
 Roberts, Mrs. Burch J., 62 Chenocetah Dr., Cornelia
 Walker, Mrs. Jesse Lee, Clarkesville
 Walter, Mrs. Austin J., Sautee

HALL COUNTY

Banks, Mrs. Rafe, Jr., 2 Glenwood Dr., Gainesville
 Brown, Mrs. P. F., Jr., 1657 Riverside Dr., Gainesville
 Burns, Mrs. John, 819 Green St., Gainesville
 Davis, Mrs. J. B., 1131 Green St. Cir., Gainesville
 Dixon, Mrs. P. K., Longview Ave., Gainesville
 Garner, Mrs. W. R., 380 North Green St., Gainesville
 Ghent, Mrs. Oliver, Thompson Bridge Rd., Gainesville
 Gilbert, Mrs. B. P., Hillside Dr., Gainesville
 Hardman, Mrs. Billy, Cleveland Rd., Gainesville
 Howard, Mrs. Marcus, Dahlonega
 Jennings, Mrs. Henry, Simmons St., Gainesville
 Joiner, Mrs. Hartwell, 242 Dixon Dr., Gainesville
 Lancaster, Mrs. H. H., New Holland
 McCarver, Mrs. W. C., Blue Ridge Rd., Gainesville
 McCrum, Mrs. Bart, 649 Perry St., Gainesville
 Meeks, Mrs. Jesse, 213 Brenau Ave., Gainesville
 Murray, Mrs. Hamil, Lanier Ave., Gainesville
 Newman, Mrs. Harvey, III, Moss Hill Apartments, Gainesville
 Reed, Mrs. John, 330 Academy St., Gainesville
 Rogers, Mrs. R. L., 127 Academy St., Gainesville
 Simons, Mrs. D. C., Dahlonega
 Smith, Mrs. Martin, Dixon Dr., Gainesville
 Valentine, Mrs. H. E., 950 Wessels Rd., Gainesville
 Ward, Mrs. E. L., 615 North Green St., Gainesville
 Whelchel, Mrs. C. D., 1647 Riverside Dr., Gainesville
 Whitworth, Mrs. C. W., Wessels Rd., Gainesville
 Woodward, Mrs. J. G., Dahlonega

TRI-COUNTY (Hart-Franklin-Elbert)

Cacchioli, Mrs. Louis Gregory, Hartwell
 Carnes, Mrs. Wm. Carothers, Hartwell
 Milford, Mrs. James Hubert, Hartwell
 Jenkins, Mrs. Joseph Isham, Hartwell
 Brown, Mrs. Stewart Dixon, Sr., Royston
 Brown, Mrs. Stewart Dixon, Jr., Royston
 Bailey, Mrs. David Vernon, Elberton
 Mickel, Mrs. Carey, Jr., Elberton
 Pool, Mrs. Winford Homer, Elberton
 Thompson, Mrs. Dallas Norman, Elberton

JACKSON-BARROW

Adams, Mrs. J. K., Jefferson
 Almond, Mrs. C. B., Winder
 Etheridge, Mrs. E. A., Winder

Harris, Mrs. E. R., Winder
 McDonald, Mrs. E. M., Winder
 McElhannon, Mrs. F. M., Winder
 Randolph, Mrs. W. T., Winder
 Skelton, Mrs. C. B., Winder
 Whitley, Mrs. J. R., Winder

LOWNDES COUNTY

Austin, Mrs. G. J., Jr., 403 Clyde Ave., Valdosta
 Brannen, Mrs. J. H., 2209 Glendale, Valdosta
 Burns, Mrs. D. L., 1407 Williams St., Valdosta
 Dismuke, Mrs. James Clyde, Adel
 Eldridge, Mrs. F. G., 1417 Williams St., Valdosta
 Giddens, Mrs. I. S., Lakeland
 Johnson, Mrs. A. M., 1612 Oak St., Valdosta
 Little, Mrs. Alex G., Jr., Country Club Dr., Valdosta
 Mixson, Mrs. E. Harry, 200 High St., Valdosta
 Mixson, Mrs. Joyce F., Jr., 303 Georgia Ave., Ext., Valdosta
 Newlin, Mrs. L. K., 2214 Glyndale Dr., Valdosta
 Owens, Mrs. B. G., 111 East Alden Ave., Valdosta
 Peters, Mrs. James S., Nashville
 Retterbush, Mrs. W. C., 2107 Hillcrest Dr., Valdosta
 Robbins, Mrs. Allen Isaac, Homerville
 Sherman, Mrs. Henry T., Carolyn Apartments, Valdosta
 Smith, Mrs. J. Gregg, Baytree Rd., Valdosta
 Smith, Mrs. Louis, Lakeland
 Smith, Mrs. J. R., Hahira
 Stump, Mrs. Robert L., Jr., 1620 Boone Dr., Valdosta
 Thompson, Mrs. E. F., 1718 Williams St., Valdosta
 Turner, Mrs. J. D., Nashville
 Wade, Mrs. V. C., 318 East Central Ave., Valdosta
 Williams, Mrs. T. C., 218 Georgia Ave., Valdosta
 Winston, Mrs. Richard K., 505 North Patterson St., Valdosta

MUSCOGEE COUNTY

Berman, Mrs. Dave, 1918 Country Club Rd., Columbus
 Berry, Mrs. Arthur N., 1660 Flournoy Dr., Columbus
 Bickerstaff, Mrs. Hugh J., 2228 Wildwood, Columbus
 Blanchard, Mrs. Mercer, 1543 Eberhart, Columbus
 Blanchard, Mrs. Mercer C., 949 Blandford, Columbus
 Bradshaw, Mrs. Randolph G., La Delle Apartments, Columbus
 Brannen, Mrs. O. C., 1318 Stuart Ave., Columbus
 Brill, Mrs. Harry H., 1315 Peacock Ave., Columbus
 Brocato, Mrs. Simone, 2009 Cherokee Dr., Columbus
 Bush, Mrs. John, 1600 Sixteenth Ave., Columbus
 Butler, Mrs. Clarence C., 3217 Catherine, Columbus
 Cain, Mrs. Elisha J., 1240 Wildwood, Columbus
 Chastain, Mrs. Joseph B., 2214 Fourteenth St., Columbus
 Chipman, Mrs. R. A., 1234 Peacock Ave., Columbus
 Clifford, Mrs. W. S., 1509 4th Ave., Columbus
 Comstock, Mrs. George, 2216 Amos St., Columbus

Conger, Mrs. A. B., 1231 Peacock, Columbus
 Conn. Mrs. Lee Roy, 2800 Gardenia, Columbus
 Conner, Mrs. George R., 2517 Hilton, Columbus
 Cook, Mrs. William C., 926 Peachtree, Columbus
 Cooke, Mrs. W. L., 2110 Oak, Columbus
 Davidson, Mrs. Jack, 1314 Seventeenth Ave., Columbus
 Deaton, Mrs. John H., 1718 Marilon Dr., Columbus
 Dillard, Mrs. Guy, 1919 Flournoy Dr., Columbus
 Durden, Mrs. John G., Jr., 1620 Wildwood, Columbus
 Dykes, Mrs. A. N., 1617 Summit Dr., Columbus
 Edwards, Mrs. Franklin, 1122 Dinglewood, Columbus
 Elkins, Mrs. James A., 1252 Peacock Ave., Columbus
 Epps, Mrs. George L., 1638 Forest, Columbus
 Fletcher, Mrs. H. Quigg, 800 Peachtree, Columbus
 Flinchum, Mrs. Darius, 1809 Slade Dr., Columbus
 Gibson, Mrs. Roy L., 1920 Hilton Dr., Columbus
 Gilliam, Mrs. O. D., 1715 Carter, Columbus
 Graffagnino, Mrs. P. C., 2409 Lookout Dr., Columbus
 Henderson, Mrs. C. W., 1602 Forest, Columbus
 Hirsch, Mrs. Jack, 1930 Dimon, Columbus
 Horn, Mrs. Edgar B., 1703 Park Dr., Columbus
 Hughston, Mrs. Jack C., 2001 Dimon Cir., Columbus
 Hutto, Mrs. G. M., 2004 Thirteenth, Columbus
 Jarrell, Mrs. Floyd C., 1645 Sixteenth Ave., Columbus
 Jenkins, Mrs. William F., 1636 Dixon Dr., Columbus
 Johnson, Mrs. C. Denton, 2704 Seventeenth Ave., Columbus
 Jones, Mrs. W. R., 2408 Eighteenth Ave., Columbus
 Jordan, Mrs. Willis P., 1733 Eighteenth Ave., Columbus
 Kendall, Mrs. Randall P., Green Island Hills, Columbus
 Kravtin, Mrs. A. J., 1210 Eberhart Ave., Columbus
 Land, Mrs. Polk S., 1610 Richards, Columbus
 Lapides, Mrs. Leon, Jr., Big Eddy Club Rd., Columbus
 Love, Mrs. W. G., Jr., 2327 Lookout Dr., Columbus
 Maholick, Mrs. Leonard, 4203 Lake Dr., Columbus
 Mayher, Mrs. Will E., 1112 Dinglewood, Columbus
 McDuffie, Mrs. James, 1312 East Tenth St., Columbus
 Monaco, Mrs. Ralph A., 1414 Peacock Ave., Columbus
 Munn, Mrs. E. K., 9 Park Dr., Columbus
 Newlin, Mrs. L. K., Valdosta
 Newsom, Mrs. Bruce C., 1640 Seventeenth Ave., Columbus
 Peacock, Mrs. Clifford A., 1266 Cedar Ave., Columbus
 Rhea, Mrs. James W., 1809 Carter, Columbus

Roberts, Mrs. Luther J., 2208 Springdale, Columbus
 Roddenberry, Mrs. S. A., 1303 Stark Ave., Columbus
 Schley, Mrs. Frank B., 1352 Peacock Columbus
 Schuessler, Mrs. George D., 2220 Country Club Rd., Columbus
 Serrato, Mrs. Joseph C., 2915 Cody Rd., Columbus
 Smith, Mrs. Charles, 2620 Foley Dr., Columbus
 Snelling, Mrs. W. R., 2028 Dell Dr., Columbus
 Storey, Mrs. W. Edward, 3387 Macon Rd., Columbus
 Tatum, Mrs. P. A., 1220 Sixteenth Ave., Columbus
 Taylor, Mrs. Clayton D., 2866 Gurley Dr., Columbus
 Thompson, Mrs. John B., 1630 Cherokee Ave., Columbus
 Threatte, Mrs. Bruce, 1712 Wells Dr., Columbus
 Tillery, Mrs. Bert, 1544 Cherokee Ave., Columbus
 Turner, Mrs. Haywood, Techwood Dr., Columbus
 Varner, Mrs. W. D., 1421 Eberhart, Columbus
 Vaughan, Mrs. Robert H., 2723 Wadden Dr., Columbus
 Venable, Mrs. D. R., 1523 Hilton Ave., Columbus
 Walker, Mrs. John E., Green Island Hills, Columbus
 Waller, Mrs. Roy M., 2601 Madden Dr., Columbus
 Ward, Mrs. James, 1541 Dixon Dr., Columbus
 Willis, Mrs. J. N., 1240 Cedar Ave., Columbus
 Wolff, Mrs. Luther H., 1818 Slade Dr., Columbus
 Youmans, Mrs. J. R., 1600 Boulevard St., Columbus
 Dashiell, Mrs. Waverly B., Nancy St., Columbus
 Hazouri, Mrs. Louis A., 1253 Peacock, Columbus

NEWTON-ROCKDALE

Brown, Mrs. Joe C., Conyers
 Callaway, Mrs. E. Jordan, 616 Brookwood Cir., Covington
 Griggs, Mrs. Harvey, Conyers
 Martin, Mrs. Robert, Conyers
 Mitchell, Mrs. J. B., Jr., Porterdale
 Nesbit, Mrs. F. C., 551 Legion Dr., Covington
 Palmer, Mrs. C. B., 507 East Conyers St., Covington
 Paty, Mrs. R. Morris, Oxford
 Sams, Mrs. J. Roscoe, 607 Pennington St., Covington
 Swann, Mrs. W. K., 308 Floyd St., Covington
 Tuck, Mrs. Goodwin G., 1034 Phedora St., Covington
 Waites, Mrs. S. L., 307 Floyd St., Covington

RANDOLPH-TERRELL

Arnold, Mrs. John T., Parrott
 Elliott, Mrs. W. G., Cuthbert
 Harper, Mrs. T. F., Coleman
 Martin, Mrs. F. M., Shellman
 Martin, Mrs. R. D., Cuthbert
 Martin, Mrs. W. D., Dawson
 Mayo, Mrs. E. A., Richland
 Patterson, Mrs. J. C., Cuthbert
 Pugh, Mrs. C. M., Lumpkin
 Rogers, Mrs. F. S., Coleman
 Sims, Mrs. A. R., Richland
 Sims, Mrs. F. E., Dawson

Ward, Mrs. J. A., Shellman

RICHMOND COUNTY

Agee, Mrs. M. Preston, 3028 Cardinal Dr., Augusta
 Agostas, Mrs. William N., 2845 Lombady Court, Augusta
 Bailey, Mrs. Thomas E., 2548 Central Ave., Augusta
 Barfield, Mrs. William E., 802 Russell St., Augusta
 Battey, Mrs. Alfred M., Jr., 3011 Lake Forest Dr., Augusta
 Battey, Mrs. Louis L., 1138 Glenn Ave., Augusta
 Battey, Mrs. William W., 2239 Kings Way, Augusta
 Bazemore, Mrs. J. Malcolm, 3023 Pine Needle Rd., Augusta
 Beard, Mrs. Byron C., Walton Way Extension, Augusta
 Bedingfield, Mrs. Wade R., 2529 Walton Way, Augusta
 Bell, Mrs. Jack E., 2211 Crestwood Dr., Augusta
 Bennett, Mrs. James W., 2132 Cumming Rd., Augusta
 Bohorfoush, Mrs. Joseph G., Veterans Administration Hospital, Augusta
 Bowen, Mrs. John B., 2505 Henry St., Augusta
 Bowles, Mrs. Lesler L., 2625 Oakland Dr., Augusta
 Boyd, Mrs. William S., 2315 Laurel Lane, Augusta
 Brittingham, Mrs. John W., 3046 Pine Needle Rd., Augusta
 Brown, Mrs. Stephen W., 2922 Bransford Rd., Augusta
 Bryans, Mrs. Charles I., Jr., 1030 Katherine St., Augusta
 Burdshaw, Mrs. William J., 718 Monte Sano Ave., Augusta
 Butler, Mrs. James H., 1103 Milledge Rd., Augusta
 Callahan, Mrs. Dan, 678 Lorraine Dr., North Augusta, S. C.
 Carswell, Mrs. Augustin S., 2636 Central Ave., Augusta
 Carter, Mrs. Curtis H., 1003 Blue Bird Rd., Augusta
 Chandler, Mrs. John L., 2923 Lake Forest Dr., Augusta
 Chaney, Mrs. Ralph H., Sr., 2918 Bransford Rd., Augusta
 Clary, Mrs. Thomas L., Jr., 1329 Highland Ave., Augusta
 Crichton, Mrs. Robert B., 2520 Richmond Hill Rd., Augusta
 DeVaughn, Mrs. Nathan M., 802 Monte Sano Ave., Augusta
 Dixon, Mrs. Ellis, Box 28, Rt. 4, Washington
 Ellison, Mrs. Robert G., 1116 Kirk Pl., Augusta
 Everett, Mrs. Theodore, Maxwell House Apartments, Augusta
 Faulkner, Mrs. John A., Walton Way Extension, Augusta
 Flanagan, Mrs. W. Stewart, 2620 Oakland Dr., Augusta
 Friedman, Mrs. Charles, Jr., Country Club Apartments, Augusta
 Friedman, Mrs. Seymour, 1132 Druid Park Ave., Augusta
 Fuller, Mrs. William A., Overton Rd., Augusta
 Goldberg, Mrs. Ira, Country Club Apartments, Augusta
 Goodwin, Mrs. Thomas W., 3026 Bransford Rd., Augusta
 Hair, Mrs. L. Quinby, 2485 Coleman Ave., Augusta

Hamilton, Mrs. Wm. F., Jr., 2852 Pine View Rd., Augusta
 Harper, Mrs. Harry T., 2739 Walton Way, Augusta
 Harrison, Mrs. Frank Nickolas, 5038 Milledgeville Rd., Rte. 2, Augusta
 Hastings, Mrs. E. Val, 758 Malvern Lane, Augusta
 Henry, Mrs. C. Goodrich, 1710 Holly Hill Rd., Augusta
 Hitchcock, Mrs. J. Phinzy, 627 Milledge Rd., Augusta
 Hock, Mrs. Charles W., 909 Highland Ave., Augusta
 Holmes, Mrs. L. Palmer, 2810 Hillcrest Ave., Augusta
 Hopkins, Mrs. Enon C., 3020 Cardinal Dr., Augusta
 Howard, Mrs. Thomas J., 671 Milledge Rd., Augusta
 Hudson, Mrs. Jack, 1611 Cornell Dr., Augusta
 Hummell, Mrs. J. Emile, 1747 Pine Tree Rd., Augusta
 Jennings, Mrs. William D., Jr., 410 Ashland Dr., Augusta
 Jones, Mrs. G. Frank, Jr., 2313 Laurel Lane, Augusta
 Kay, Mrs. James B., Jr., 3033 Pine Needle Rd., Augusta
 Kelly, Mrs. G. Lombard, 2131 Gardner St., Augusta
 Kelly, Mrs. Gordon M., 2233 McDowell St., Augusta
 Klemann, Mrs. Gilbert L., 2815 Richmond Hill Rd., Augusta
 Lee, Mrs. F. Lansing, 901 Heard Ave., Augusta
 Leonard, Mrs. Robert E., 2908 Lake Forest Dr., Augusta
 Luther, Mrs. Charles G., 625 Milledge Rd., Augusta
 Major, Mrs. Robert C., 402 Magnolia Dr., Augusta
 Manganiello, Mrs. Louis O., 3028 Bransford Rd., Augusta
 Manter, Mrs. John T., 1614 Pendleton Rd., Augusta
 Martin, Mrs. John M., Milledgeville Rd., Box 502, Rt. 2, Augusta
 Massengale, Mrs. Leonard R., 2333 Laurel Lane, Augusta
 Matthews, Mrs. W. Eugene, 2735 Walton Way, Augusta
 McGahee, Mrs. Robert C., 2817 Hillcrest Ave., Augusta
 McGinty, Mrs. Howard C., 1001 Hickman Rd., Augusta
 McInnes, Mrs. George F., 2311 Laurel Lane, Augusta
 McKnight, Mrs. Robert R., 949 Johns Rd., Augusta
 McRae, Mrs. Donald R., Jr., 1127 Kirk Place, Augusta
 Mealing, Mrs. Henry G., 103 Forest Ave., Augusta
 Miller, Mrs. Abraham Walter, 314 Broad St., Augusta
 Miller, Mrs. John W., 2837 Helen St., Augusta
 Milligan, Mrs. King W., 942 Greene St., Augusta
 Mulherin, Mrs. Charles, 2236 McDowell St., Augusta
 Mulherin, Mrs. Frank X., 2704 Henry St., Augusta
 Mulherin, Mrs. Joseph, 2212 Crestwood Dr., Augusta
 Mullins, Mrs. D. Frank, Jr., 2749 Hillcrest Ave., Augusta
 Nichols, Mrs. Pomeroy, Jr., Maxwell House Apartments, Augusta

O'Rear, Mrs. Harry B., 1734 Wycliff Rd., Augusta
 Payne, Mrs. Rufus F., 3404 Walton Way Extension, Augusta
 Perkins, Mrs. Henry R., 1118 Milledge Rd., Augusta
 Philpot, Mrs. William K., 2423 Kings Way, Augusta
 Phillips, Mrs. Hayward S., 1082 Bertram Rd., Augusta
 Pinson, Mrs. Harry D., 3412 Walton Way Extension, Augusta
 Pou, Mrs. Leo H., Jr., 1608 Bryn Mawr, Augusta
 Pund, Mrs. Edgar R., 1108 Glenn Ave., Augusta
 Redd, Mrs. Bryan L., Jr., 3221 Alpine, Augusta
 Rhodes, Mrs. Robert L., 2501 Bellevue Ave., Augusta
 Rinker, Mrs. J. Robert, 2111 Gardner St., Augusta
 Rushia, Mrs. Edwin L., 3050 Hillsdale Dr., Augusta
 Sell, Mrs. M. Brannon, 1802 Curtis Dr., North Augusta, S. C.
 Shepeard, Mrs. Walter L., 2858 Pineview Rd., Augusta
 Sherman, Mrs. John H., 2251 Walton Way, Augusta
 Smith, Mrs. C. Conrad, 3005 Cardinal Dr., Augusta
 Steed, Mrs. William A., 2803 Ingleside Dr., Augusta
 Stevenson, Mrs. Gilbert M., 2410 Comanche Rd., Augusta
 Templeton, Mrs. C. Monroe, 910 Carolina Ave., North Augusta, S. C.
 Tessier, Mrs. Claude B., 1320 Buena Vista Rd., Augusta
 Thigpen, Mrs. Corbett H., 815 Dogwood Lane, Augusta
 Thomas, Mrs. David R., Jr., 630 Gary Dr., Augusta
 Thompson, Mrs. Thomas C., 1303 Monte Sano Ave., Augusta
 Thurmond, Mrs. J. William, 855 Old Edgefield Rd., North Augusta, S. C.
 Torpin, Mrs. Richard, 2618 Walton Way, Augusta
 Traylor, Mrs. George A., 2311 Kings Way, Augusta
 Volpitto, Mrs. Perry P., 3024 Bransford Rd., Augusta
 Waters, Mrs. A. Jack, 2209 Morningside Dr., Augusta
 White, Mrs. Cecil A., 1614 Bryn Mawr, Augusta
 White, Mrs. William O., Jr., 2910 Lake Forest Dr., Augusta
 Wilkes, Mrs. William A., 1203 Highland Ave., Augusta
 Williams, Mrs. David C., Jr., 804 Russell St., Augusta
 Williams, Mrs. William J., 1107 Johns Rd., Augusta
 Witham, Mrs. A. Calhoun, 1103 Peachtree Rd., Augusta
 Wylie, Mrs. M. Hardeman, 2427 Walton Way, Augusta
 Wright, Mrs. Peter B., 3037 Park Ave., Augusta

SPALDING COUNTY

Austin, Mrs. J. L., 778 College Street East, Griffin
 Black, Mrs. Grady E., 721 Springer Dr., Griffin
 Brandon, Mrs. Robert Vernon, Conyers Rd., McDonough
 Brown, Mrs. George W., 672 East College, Griffin
 Clouse, Mrs. John E., Jr., 145 Milner Ave., Griffin

Copeland, Mrs. H. J., 615 East College, Griffin
 Cox, Mrs. Joel E., 38 Terracedale Court, Griffin
 Felder, Mrs. Lewis H., McDonough
 Foster, Mrs. Gordon Robert, Jr., McDonough
 Fitzhugh, Mrs. Alexander S., Jr., East College Street Ext., Griffin
 Floyd, Mrs. Thomas J., Jr., 643 Brook Circle, Griffin
 Frye, Mrs. Augustus H., Jr., Box 771, Griffin
 Henry, Mrs. George T., 414 Spencer St., Barnesville
 Hicks, Mrs. Wright G., Jackson
 Hunt, Mrs. Kenneth S., 121 West College, Griffin
 Jones, Mrs. Alexander P., 561 Crescent Rd., Griffin
 King, Mrs. Harry C., Crescent Rd., Griffin
 King, Mrs. William R., Jr., Woodland Dr., Griffin
 Montero, Mrs. Enrique, 672 McLaurin St., Griffin
 Smaha, Mrs. Tofey G., 836 Maple Dr., Griffin
 Thomas, Mrs. James R., Route 3, Box 262-A, Griffin
 Walker, Mrs. George L., Jr., 709 Maple Dr., Griffin
 Williams, Mrs. Virgil B., 505 Brookwood Terrace, Griffin

STEPHENS COUNTY

Ayers, Mrs. Clarence L., Toccoa
 Harp, Mrs. S. L., Toccoa
 McNeely, Mrs. Henry H., Toccoa
 Pittard, Mrs. M. D., Toccoa
 Schaefer, Mrs. Bruce, Toccoa
 Shiflet, Mrs. R. E., Toccoa

SUMTER COUNTY

Anderson, Mrs. William R., Americus
 Bennett, Mrs. W. Fred, Buena Vista
 Boyette, Mrs. Linton S., Ellaville
 Cheves, Mrs. Langdon C., Jr., Montezuma
 Durham, Mrs. Bon M., Americus
 Fenn, Mrs. Henry R., Americus
 Gatewood, Mrs. T. S., Americus
 Logan, Mrs. Joseph Colquitt, Plains
 McMath, Mrs. William Bates, Americus
 Pendergrass, Mrs. R. C., Americus
 Primrose, Mrs. A. C., Americus
 Robinson, Mrs. John H., III, Americus
 Savage, Mrs. C. P., Montezuma
 Smith, Mrs. Herschel A., Americus
 Thomas, Mrs. Russell, Americus
 Waldemayer, Mrs. Ennis W., Americus
 Wilson, Mrs. Frank Adam, III, Leslie

THOMAS COUNTY

Baldwin, Mrs. Marion A., 943 South Broad, Thomasville
 Bell, Mrs. Rudolph, 425 North Dawson, Thomasville
 Cheshire, Mrs. Howard L., 407 Park Ave., Thomasville
 Collins, Mrs. Jack J., 612 South Broad, Thomasville
 Davis, Mrs. E. E., Meigs
 Dillinger, Mrs. George R., 1304 Washington, Thomasville
 King, Mrs. John T., Monticello Rd., Thomasville
 McCollum, Mrs. William, Euclid Dr., Thomasville
 Mims, Mrs. Oscar M., Woodlawn Apartments, Thomasville
 Murphy, Mrs. Fred E., 1008 Gordon Ave., Thomasville
 Neel, Mrs. Julian B., 322 Park Ave., Thomasville

Pepin, Mrs. Henry S., Junius St., Thomasville
 Reading, Mrs. Herbert F., 143 Edgewood Dr., Thomasville
 Shipp, Mrs. C. Carlton, Circle Dr., Thomasville
 Stinson, Mrs. Roy F., Myrtle Dr., Thomasville
 Taylor, Mrs. Warren A., Gordon Ave., Thomasville
 Wasden, Mrs. Howell A., Pavo
 Watt, Mrs. Charles H., Sr., 602 North Dawson, Thomasville
 Watt, Mrs. Charles H., Jr., 319 North Hansell, Thomasville
 Wine, Mrs. Mervin B., 917 Broad St., Thomasville

TIFT COUNTY

Andrews, Mrs. Agnew, 1205 Murray Ave., Tifton
 Bridges, Mrs. W. L., Jr., 1012 Love Ave., Tifton
 Edmondson, Mrs. Tom L., 704 West 14th St., Tifton
 Evans, Mrs. E. L., 18th St., Tifton
 Fleming, Mrs. Carlton A., 1008 Hall Ave., Tifton
 Flowers, Mrs. E. M., 1404 Hall Ave., Tifton
 Harrell, Mrs. B. D., 418 North Central Ave., Tifton
 Jones, Mrs. R. E., 1014 Love Ave., Tifton
 Lucas, Mrs. Paul W., 617 Wilson Ave., Tifton
 Pickett, Mrs. Frank, Ty Ty
 Pittman, Mrs. C. S., Sr., 211 Twelfth St., Tifton
 Pittman, Mrs. C. S., Jr., Eighteenth St., Tifton
 Zimmerman, Mrs. Charles, West Eighth St., Tifton
 Zimmerman, Mrs. William F., West Eighth St., Tifton

TROUP COUNTY

Arnold, Mrs. E. T., Jr., Hogansville
 Avery, Mrs. R. M., West Point Rd., LaGrange
 Callaway, Mrs. Enoch, 310 Broad, LaGrange
 Chambers, Mrs. J. W., 226 McLendon, LaGrange
 Cowart, Mrs. C. T., 1007 Broad, LaGrange
 Easley, Mrs. Curran S., Jr., 114 Ridgecrest Rd., LaGrange
 Fackler, Mrs. W. B., 108 Springdale, LaGrange
 Grace, Mrs. Kenneth D., 512 Park Ave., LaGrange
 Grady, Mrs. Henry W., 1400 Vernon Rd., LaGrange
 Hammett, Mrs. H. H., Jr., 104 Ridgecrest Rd., LaGrange
 Hammett, Mrs. H. H., Sr., 201 Gordon, LaGrange
 Hand, Mrs. Hollis, Country Club Rd., LaGrange
 Hendricks, Mrs. W. M., 322 Country Club Rd., LaGrange
 Herault, Mrs. P. C., 109 Westwood Dr., LaGrange
 Herman, Mrs. E. C., 205 Gordon, LaGrange
 Holder, Mrs. J. S., 1402 Vernon Rd., LaGrange
 Lane, Mrs. J. E., 400 Gordon, LaGrange
 Mitchell, Mrs. J. T., 206 Park Ave., LaGrange
 Molyneaux, Mrs. E. W., Hogansville
 Morgan, Mrs. D. E., Lane Circle, LaGrange
 Morgan, Mrs. P. C., Jr., West Point

Norman, Mrs. Lewis, West Point
 O'Neal, Mrs. R. S., Piney Woods Dr., LaGrange
 Park, Mrs., E. R., 104 Gordon, LaGrange
 Prescott, Mrs. E. H., 121 Dilly Hill, LaGrange
 Whitehead, Mrs. Mark, Cherokee Ave., LaGrange

UPSON COUNTY

Blackburn, Mrs. John Davies, 711 Hill St., Thomaston
 Dallas, Mrs. Robert Edwin, P. O. Box 769, Thomaston
 Gower, Mrs. William Justus, Jr., Avalon Rd., Thomaston
 Head, Mrs. Douglas Lamar, Jr., P. O. Box 807, Thomaston
 Kellum, Mrs. John Morgan, Avalon Rd., Thomaston
 Mincey, Mrs. Rollo J., Jr., Avalon Rd., Thomaston
 Sappington, Mrs. Thomas Asbury, Canton Pines, Thomaston
 Scott, Mrs. Morgan Eugene, P. O. Box 808, Thomaston
 Tyler, Mrs. Herbert Daniel, 507 Hill St., Thomaston
 Woodall, Mrs. James A., 744 Andrews Dr., Thomaston
 Woodall, Mrs. William Pruett, P. O. Box 788, Thomaston

WARE COUNTY

Adkins, Mrs. Henry Thomas, 2007 Cherokee Dr., Waycross
 Bates, Mrs. William Bowers, Jr., 802 Elizabeth St., Waycross
 Bradley, Mrs. Daniel Marcus, 629 Nichols St., Waycross
 Bussell, Mrs. Benjamin Randolph, 604 Euclid Ave., Waycross
 Calhoun, Mrs. William Clifton, Oconee Rd., Waycross
 Davis, Mrs. Floyd Eugene, 1106 Satilla Boulevard, Waycross
 DeLoach, Mrs. Arthur William, 1015 Cherokee Dr., Waycross
 Ferrell, Mrs. Thomas Joseph, 1521 St. Mary's Dr., Waycross
 Flanagan, Mrs. Wiley Monroe, 909 Carswell Ave., Waycross
 Flesch, Mrs. Wilbur Lawrence, 104 Pennsylvania Ave., Waycross
 Folks, Mrs. William Morgan, 2201 Cherokee Dr., Waycross
 Hafford, Mrs. Wilbur Clair, 229 Riverside Dr., Waycross
 Hooker, Mrs. James Frank, 1509 Mimosa Place, Waycross
 Jackson, Mrs. Joseph, Folkston
 Jacobs, Mrs. Ivy, 615 McDonald St., Waycross
 Knight, Mrs. Arthur Merrill, Jr., 110 Thomas St., Waycross
 Massey, Mrs. Clayton McDonald, 807 Richmond Ave., Waycross
 McGoogan, Mrs. Malcolm Thomas, Jr., 705 Fern St., Waycross
 Minchew, Mrs. Benjamin Harvey, 412 Williams St., Waycross
 Muecke, Mrs. Harold Wright, 510 Dean Dr., Waycross
 Penland, Mrs. John Erwin, 912 Elizabeth Dr., Waycross
 Pierce, Mrs. Lovick Wiles, 1201 Seminole Trail, Waycross
 Pomeroy, Mrs. William Loomis, 1421 St. Mary's Dr., Waycross
 Reavis, Mrs. Wm. Farrell, 1105 Satilla Boulevard, Waycross
 Seaman, Mrs. Henry Ansley, 802 Brunel St., Waycross

Smith, Mrs. Leo, 1507 St. Mary's Dr., Waycross
 Terry, Mrs. Daniel Bronson, Homerville
 Victor, Mrs. Samuel, 1010 Seminole Trail, Waycross
 Yeomans, Mrs. Neal Franklin, 602 Magnolia Dr., Waycross

WASHINGTON COUNTY

Dillard, Mrs. J. B., Davisboro
 Lever, Mrs. Joseph E., Sandersville
 McElreath, Mrs. F. T., Tennille
 Newsome, Mrs. N. J., Sandersville
 Newsome, Mrs. Emory G., Sandersville
 Overby, Mrs. N., Sandersville
 Rawlings, Mrs. F. B., Sandersville

WHITFIELD COUNTY

Ault, Mrs. Jacent Henry, 401 Selvidge St., Dalton
 Boozer, Mrs. Albert M., Stoneleigh Dr., Dalton
 Bradley, Mrs. Paul L., 303 Valley Dr., Dalton
 Broadrick, Mrs. George L., 209 King St., Dalton
 Erwin, Mrs. Harlan Lamar, 203 Cleveland St., Dalton
 Kerr, Mrs. George Stafford, Chatsworth Rd., Dalton
 McGhee, Mrs. Earl, Lakemont Dr., Dalton
 Mullins, Mrs. James N., Chatsworth
 Rosen, Mrs. Eli A., 200 Lynn St., Dalton
 Starr, Mrs. Trammell, 201 N. Thornton Ave., Dalton
 Summerour, Mrs. Brooke F., 925 Stoneleigh Rd., Dalton
 Wells, Mrs. David A., West Cuyler St., Dalton
 Whitfield, Mrs. Truman W., 300 Lynn St., Dalton
 Wood, Mrs. David Lloyd, 207 North Thornton Ave., Dalton
 Yeargin, Mrs. Lloyd G., Chatsworth

WORTH COUNTY

Crowe, Mrs. Norman, J., 403 East Wallace, Sylvester
 Davis, Mrs. H. G., Jr., 403 North Henderson, Sylvester
 Methvin, Mrs. S. R., Box 328 Sylvester
 Stoner, Mrs. W. P., Moore St., Sylvester
 Sumner, Mrs. Gordon S., 302 North Westberry, Sylvester
 Tracy, Mrs. J. L., Jr., 508 North Main St., Sylvester
 Tracy, Mrs. J. L., Sr., 207 East Kelly, Sylvester

MEMBERS-AT-LARGE

Arnold, Mrs. James H., Newman
 Arnold, Mrs. Maurice F., Hawkinsville
 Baker, Mrs. W. R., Columbus Rd., Hawkinsville
 Bennett, Mrs. Robert L., Warm Springs
 Bryant, Mrs. James M., Jr., Newnan
 Busey, Mrs. T. J., Fayetteville
 Campbell, Mrs. Richard H., Cedartown
 Elliott, Mrs. Cecil B., Cedartown
 Ellis, Mrs. W. P., Chipley
 Glover, Mrs. Howard C., Jr., Newnan
 Goldman, Mrs. Benjamin, Hazlehurst
 Hammond, Mrs. George W., Newnan
 Harwell, Mrs. C. W., Camilla
 Hendrick, Mrs. A. G., 1100 Swift St., Perry
 Jenkins, Mrs. Ben H., Newnan
 Kirkland, Mrs. W. P., Manchester
 Lewis, Mrs. J. R., Louisville
 McArthur, Mrs. J. D., Lyons
 McBryde, Mrs. T. E., Rockmart
 Pilcher, Mrs. John J., Wrens
 Pinkston, Mrs. A. G., Glennville
 Schmidt, Mrs. Donald W., Cedartown
 Smith, Mrs. Julian, Rockmart
 Wright, Mrs. Jones T., Donalsonville

MAG Officers and Committees

OFFICERS, 1955-1956

President—H. Dawson Allen, Jr., Milledgeville
President-Elect—Hal M. Davison, Atlanta
Immediate Past President—William Harbin, Rome
First Vice-President—R. C. McGahee, Augusta
Second Vice-President—Stephen W. Brown, Augusta
Secretary-Treasurer—David Henry Poer, Atlanta

Delegates to the A.M.A.

Terms Expire December 31, 1957

C. H. Richardson, Sr., Macon
C. L. Ayers, Toccoa, Alternate

Terms Expire December 31, 1956

Eustace A. Allen, Atlanta
William R. Dancy, Savannah, Alternate
Spencer Kirkland, Atlanta
Henry Tift, Macon, Alternate

Councilors

District	Term Expires
1—Lee Howard, Savannah	1958 Session
2—George R. Dillinger, Thomasville	1958 Session
3—W. G. Elliott, Cuthbert	1958 Session
4—J. W. Chambers, LaGrange, Chairman	1958 Session
5—Mark S. Dougherty, Jr., Atlanta	1956 Session
6—Henry H. Tift, Macon	1956 Session
7—D. Lloyd Wood, Dalton	1956 Session
8—Neal F. Yeomans, Waycross	1956 Session
9—W. Bruce Schaefer, Toccoa	1957 Session
10—H. L. Cheves, Union Point	1957 Session

Vice-Councilors

District	Term Expires
1—Charles T. Brown, Guyton	1958 Session
2—J. Z. McDaniel, Albany	1958 Session
3—Luther H. Wolff, Columbus	1958 Session
4—Clarence B. Palmer, Covington	1958 Session
5—J. G. McDaniel, Atlanta	1956 Session
6—H. G. Weaver, Macon	1956 Session
7—Ralph W. Fowler, Marietta	1956 Session
8—James M. Hicks, Brunswick	1956 Session
9—Charles R. Andrews, Jr., Canton	1957 Session
10—J. Victor Roule, Augusta	1957 Session

Executive Committee

H. Dawson Allen, Jr., Milledgeville, President
Hal M. Davison, Atlanta, President-Elect
William Harbin, Rome, Immediate Past President
David Henry Poer, Atlanta, Secretary-Treasurer
J. W. Chambers, LaGrange, Chairman of Council
W. Bruce Schaefer, Toccoa, Member of Council

Committee on Auditing and Appropriations

W. Bruce Schaefer, Toccoa, Chairman
D. Lloyd Wood, Dalton
Mark S. Dougherty, Jr., Atlanta

Honorary Advisory Board

J. W. Palmer	President, 1918-1919
C. K. Sharp	President, 1928-1929
William R. Dancy	President, 1929-1930
M. M. Head	President, 1932-1933
C. H. Richardson	President, 1933-1934
Clarence L. Ayers	President, 1934-1935
B. H. Minchew	President, 1936-1937
Grady N. Coker	President, 1938-1939
J. C. Patterson	President, 1940-1941
Allen H. Bunce	President, 1941-1942
James A. Redfearn	President, 1942-1943
W. A. Selman	President, 1943-1944
Cleveland Thompson	President, 1944-1946
Ralph H. Chaney	President, 1946-1947
Enoch Callaway	President, 1949-1950
A. M. Phillips	President, 1950-1951
W. F. Reavis	President, 1951-1952
C. F. Holton	President, 1952-1953
William Harbin	President, 1953-1954
Peter B. Wright	President, 1954-1955

STANDING COMMITTEES, 1955-56

(One member appointed annually to serve for 3 years—terms expire at Annual Session)

Scientific Work

Fred H. Simonton, Chickamauga, Chairman
H. C. Atkinson, Macon David Henry Poer, Atlanta
Thomas W. Goodwin, Augusta H. D. Allen, Jr., Milledgeville

Legislation

Grady N. Coker, Canton, Chairman
William Harbin, Rome, Co-Chairman
Carl C. Aven, Atlanta Jack C. Norris, Atlanta
Joseph D. McElroy, Atlanta Albert M. Deal, Statesboro

Medical Education

Edgar R. Pund, Augusta, Chairman
Harry B. O'Rear, Augusta J. K. Quattlebaum, Savannah
R. Hugh Wood, Emory U. Arthur P. Richardson, Emory U.

Medical Defense

David Henry Poer, Atlanta, Chairman
Perry P. Volpitto, Augusta John McPherson, Jr., Athens

Professional Conduct

A. M. Phillips, Macon, Chairman
W. F. Reavis, Waycross William Harbin, Rome
C. F. Holton, Savannah Peter B. Wright, Augusta

History and Vital Statistics

J. Calvin Weaver, Atlanta, Chairman
Peter L. Scardino, Savannah Hoke Wammock, Augusta

Public Health

T. A. Sappington, Thomaston, Chairman
Duncan Shepard, Atlanta L. Minor Blackford, Atlanta
George T. Nicholson, Cornelia J. E. Scarborough, Atlanta
R. F. Spanjer, Cedartown David R. Thomas, Jr., Augusta
Grady N. Coker, Canton J. C. Thoroughman, Atlanta
Edgar M. Dunstan, Atlanta T. F. Sellers, Atlanta, Ex-Officio
Peter Hydrick, College Park Rives Chalmers, Atlanta
J. C. Hughston, Columbus

Maternal and Infant Welfare

Peter Hydrick, College Park, Chairman
Thomas C. McPherson, Atlanta Eugene L. Griffin, Atlanta
C. M. Mulherin, Augusta F. H. Simonton, Chickamauga
Helen W. Bellhouse, Atlanta George H. Alexander, Forsyth
Hugh J. Bickerstaff, Columbus James W. Bennett, Augusta

Woman's Auxiliary

Shelley C. Davis, Atlanta, Chairman
W. G. Elliott, Cuthbert Robert C. Major, Augusta
W. Bruce Schaefer, Toccoa

Constitution and By-Laws

J. W. Chambers, LaGrange, Chairman
Thomas W. Goodwin, Augusta Eustace A. Allen, Atlanta
William Harbin, Rome David Henry Poer, Atlanta

Awards

Ted F. Leigh, Atlanta, Chairman
Hoke Wammock, Augusta Mark S. Dougherty, Atlanta
Charles H. Wasden, Macon

Industrial Health

Duncan Shepard, Atlanta, Chairman
John G. Sharpley, Savannah W. Bruce Schaefer, Toccoa
Robert M. Harbin, Jr., Rome Allen M. Collinsworth, Atlanta
Charles L. Ridley, Jr., Macon Alfred M. Battey, Augusta
George R. Conner, Columbus

Public Relations

Chris J. McLoughlin, Atlanta, Chairman
Peter L. Scardino, Savannah Robert G. Ellison, Augusta
Thomas L. Ross, Jr., Macon Eugene L. Ward, Gainesville
J. Lamont Henry, Atlanta W. C. Cook, Columbus
Stephen D. Smith, Rome Geo. R. Dillinger, Thomasville

Cancer

J. E. Scarborough, Atlanta, Chairman
Hoke Wammock, Augusta Everett L. Bishop, Atlanta
David Henry Poer, Atlanta Thomas Harrold, Macon
R. C. Pendergrass, Americus Lee Howard, Sr., Savannah
Enoch Callaway, LaGrange Neal F. Yeomans, Waycross
W. F. Jenkins, Columbus Kirk Shepard, Thomasville
John Funke, Atlanta Major F. Fowler, Atlanta
John L. Barner, Athens Wadley R. Glenn, Atlanta

SPECIAL COMMITTEES

(Appointed annually)

Medical Civil Preparedness

Edgar M. Dunstan, Atlanta, Chairman
C. A. Eberhart, Atlanta Perry P. Volpitto, Augusta
T. J. Ferrell, Waycross J. S. Skobba, Atlanta
Lee H. Battle, Jr., Rome Charles E. Dowman, Atlanta

American Medical Education Foundation

John L. Chandler, Jr., Augusta, Chairman
Edgar Woody, Jr., Atlanta, Co-Chairman
Robert R. McKnight, Augusta C. H. Richardson, Jr., Macon
James S. Holder, LaGrange Sage Harper, Douglas
Ernest F. Wahl, Thomasville C. H. Watt, Jr., Thomasville

Blood Banks

Warren B. Matthews, Atlanta, Chairman
George Dowling, Atlanta D. F. Mullins, Jr., Augusta
Walter L. Sheppard, Augusta F. H. Thompson, Albany
Lee Howard, Jr., Savannah John H. Venable, Atlanta
Mr. J. Y. Bowen, Griffin R. C. Williams, Atlanta

Abner Wellborn Calhoun Lectureship

Glenville Giddings, Atlanta, Chairman
Charles L. Prince, Savannah L. M. Freedman, Savannah
Henry H. Tift, Macon

RELATED COMMITTEES

Medical Advisory to Selective Service

William G. Hamm, Atlanta, Chairman
David Henry Poer, Atlanta, Co-chairman
Carter Smith, Atlanta S. A. Garrett, D.D.S., Atlanta
T. F. Sellers, Atlanta Chas. C. Rife, D.V.M., Atlanta
L. Minor Blackford, Atlanta Homer E. Nash, Atlanta
Cyrus W. Strickler, Jr., Atlanta Dana Hudson, R.N., Atlanta
A. O. Linch, Atlanta

First District Advisory Subcommittee

J. C. Metts, Savannah, Chm. Albert M. Deal, Statesboro
William H. Fulmer, Savannah Cleveland Thompson, Jr.,
Oscar H. Lott, Savannah Waynesboro
David B. Fillingim, Savannah A. G. Pinkston, Jr., Glennville

F. G. Eldridge, Valdosta
Lester Harbin, Rome

John T. Mauldin, Atlanta

Rural Health

George T. Nicholson, Cornelia, Chairman
T. F. Sellers, Ex-Officio, Atlanta

1—Charles T. Brown, Guyton 6—W. A. Dodd, Wrightsville
2—W. B. Stoner, Sylvester 7—D. M. Cornett, LaFayette
3—M. F. Arnold, Hawkinsville 8—Hubert Milford, Hartwell
4—T. A. Sappington, Thos'ton 9—Joe J. Arrendale, Cornelia
5—James M. Combs, Atlanta 10—C. A. Wilson, Brunswick

Insurance Board

David R. Thomas, Jr., Augusta, Chairman
Charles S. Jones, Atlanta, Co-Chairman
W. L. Pomeroy, Waycross Luther H. Wolff, Columbus
D. Lloyd Wood, Dalton John L. Elliott, Savannah
Harry D. Pinson, Augusta Herbert M. Olnick, Macon

Veterans' Affairs

Hartwell Joiner, Gainesville, Chairman
A. R. Bush, Dublin Herbert S. Alden, Atlanta
A. O. Colquitt, Jr., Marietta C. C. Butler, Columbus
Bernard P. Wolff, Atlanta L. M. Freedman, Savannah
Charles R. Andrews, Canton Winston E. Burdine, Atlanta

Hospitals

Milford B. Hatcher, Macon, Chairman
H. Ansley Seaman, Waycross H. E. Weems, Perry
A. J. Davis, Augusta L. C. Yeargin, Dalton
H. A. Goodwin, Summerville W. B. Fackler, Jr., LaGrange
W. D. Hazlehurst, Macon Herbert D. Tyler, Thomaston
R. C. Williams, Atlanta, Rufus F. Payne, Augusta
Ex-Officio Robert Martin, III, Cuthbert
Ernest Thompson, Monroe

Chronic Illness

L. Minor Blackford, Atlanta, Chairman
E. F. Wahl, Thomasville A. Calhoun Witham, Augusta
Simone Brocato, Columbus J. B. Neighbors, Jr., Athens

Crawford W. Long Memorial

Lester Rumble, Jr., Atlanta, Chairman
Perry P. Volpitto, Augusta A. B. Boyd, Athens

Mental Health

Rives Chalmers, Atlanta, Chairman
J. R. Shannon Mays, Macon P. T. Scoggins, Commerce
Paul L. Schroeder, Atlanta Albert J. Kelley, Savannah
George H. Alexander, Forsyth T. J. VanSant, Jr., Marietta
Arthur M. Knight, Jr., Waycross Carl A. Whitaker, Atlanta
T. G. Peacock, Milledgeville, Consultant
Guy V. Rice, Atlanta, Consultant

Crippled Children

J. C. Hughston, Columbus, Chairman
Ruth M. Waring, Savannah James W. Bennett, Augusta
F. James Funk, Jr., Atlanta Harold W. Muecke, Waycross
John L. Chandler, Jr., Augusta

Bon M. Durham, Americus
 R. C. Pendergrass, Americus
 L. C. Cheves, Montezuma
 John E. Smith, Fitzgerald

Fourth District Advisory Subcommittee
 J. W. Chambers, LaGrange,
Chairman
 George P. Kinnard, Newnan
 J. H. Arnold, Newnan
 K. D. Grace, LaGrange
 J. S. Holder, LaGrange

Fifth District Advisory Subcommittee
 Robert W. Candler, Atlanta,
Chairman
 Joseph C. Massee, Atlanta
 Edgar M. Dunstan, Atlanta
 Sterling H. Jernigan, Atlanta
 H. H. Allen, Decatur

Sixth District Advisory Subcommittee
 John A. Bell, Jr., Dublin,
Chairman
 E. Y. Walker, Milledgeville
 O. C. Woods, Milledgeville
 M. W. Hurt, Sandersville
 J. R. S. Mays, Macon

Seventh District Advisory Subcommittee
 John M. McGehee,
 Cedartown, *Chairman*
 Roy Pope, Jr., Chickamauga
 T. A. Cochran, Ringgold
 D. L. Wood, Dalton
 Charles M. Garland, Jr.,
 Smyrna

Eighth District Advisory Subcommittee
 T. J. Ferrell, Waycross, *Chm.*
 S. T. Parkerson, McRae

Peter Graffagnino, Columbus
 Luther H. Wolff, Columbus
 Roy L. Gibson, Columbus

A. G. Little, Jr., Valdosta
 B. G. Owens, Valdosta
 H. L. Moore, Brunswick
 Sage Harper, Douglas

Ninth District Advisory Subcommittee
 Alex B. Russell, Winder, *Chm.*
 O. C. Pittman, Commerce
 John M. Hulsey, Jr.,
 Gainesville
 Edward W. Grove, Gainesville
 Robert T. Jones, III, Canton

Tenth District Advisory Subcommittee
 M. C. Adair, Washington,
Chairman
 John B. O'Neal, III, Elberton
 H. L. Cheves, Union Point
 A. S. Johnson, Sr., Elberton

Augusta Advisory Subcommittee
 C. G. Henry, Augusta, *Chairman*
 John H. Sherman, Augusta
 C. M. Mulherin, Augusta

Columbus Advisory Subcommittee
 Luther H. Wolff, Columbus, *Chairman*
 Roy Gibson, Columbus
 Peter C. Graffagnino,
 Columbus

Macon Advisory Subcommittee
 Willard R. Golsan, Macon, *Chairman*
 Charles N. Wasden, Macon
 John I. Hall, Macon

Savannah Advisory Subcommittee
 L. B. Dunn, Savannah, *Chairman*
 T. A. McGoldrick, Savannah
 J. C. Metts, Savannah

J. B. Brown, Jr., Baxley
 J. W. Yeomans, Jesup
 Jesse L. Parrott, Hahira

Chas. R. Andrews, Jr., Canton
 Joe J. Arrendale, Cornelia
 W. Bruce Schaefer, Toccoa
 W. Ben Nalley, Helen
 C. J. Roper, Jasper

M. A. Hubert, Athens
 H. T. Kennedy, Warrenton
 Albert G. LeRoy, Thomson
 Lynn M. Huie, Monroe
 J. H. Nicholson, Madison

W. K. Philpot, Augusta
 G. L. Kelly, Augusta

Polk Land, Columbus
 S. A. Roddenbery, Columbus

Harold C. Atkinson, Macon
 Thomas L. Ross, Jr., Macon

W. L. Osteen, Savannah
 Jacob Rubin, Savannah

STATE BOARDS

State Board of Medical Examiners (Meets in June and October)

Albert M. Deal, Statesboro, President—1959
 Glenville Giddings, Atlanta, President-Elect—1957
 Charles K. Wall, Thomasville—1959
 Grady N. Coker, Canton—1956
 Fred J. Coleman, Dublin—1956
 Q. A. Mulkey, Millen—1957
 R. H. McDonald, Newnan—1958
 J. W. Palmer, Ailey—1958
 Alex B. Russell, Winder—1958
 L. N. Willis, Bainbridge—1959

State Board of Health (Meets in April and October)

R. Lee Rogers, Gainesville, Chairman (9th District)—1956
 J. M. Byne Jr., Waynesboro, Vice Chairman (1st District)—
 1957
 A. G. Funderburk, Moultrie (2nd District)—1957
 O. C. Brannen, Columbus (3rd District)—1960
 Virgil P. Williams, Griffin (8th District)—1961
 Harold P. McDonald, Atlanta (5th District)—1960
 A. M. Phillips, Macon (6th District)—1956
 Fred H. Simonton, Chickamauga (7th District)—1956
 C. J. Maloy, McRae (8th District)—1956
 D. N. Thompson, Elberton (10th District)—1961

Georgia Dental Association Representatives

J. M. Hawley, Columbus—1958
 J. G. Williams, Atlanta—1958

Georgia Pharmaceutical Association Representatives

J. B. Butts, Milledgeville—1959
 W. W. Webb, Leslie—1959

State Medical Education Board (Meets in June and October)

John W. Mauldin, Alma, Chairman—1957
 J. Hubert Milford, Hartwell, Vice-Chairman—1957

C. L. Howard, Pelham—1957
 H. Dawson Allen, Jr., Milledgeville—1955-57

Medical Examiners

State Board of Workmen's Compensation

Albert A. Rayle, Atlanta
 Jack C. Norris, Atlanta
 F. Kells Boland Jr., Atlanta
 Marcus Mashburn Sr., Cumming
 Hugh Hailey, Atlanta

Hospital Advisory Council (Meets in April and October)

Representatives from Georgia Hospital Association
 Mr. Oscar Hilliard, Fort Oglethorpe, Chairman—1956
 Mr. Arthur T. Stewart, Greensboro—1955
 Mr. George E. Linney, Americus—1957

Representatives, Medical Association of Georgia
 H. Dawson Allen, Milledgeville—1956
 J. T. McCall, Rome—1956
 J. K. Quattlebaum, Savannah—1957
 Joseph C. Read, Atlanta—1957
 R. F. Spanjer, Cedartown—1955

Representative from the Georgia Dental Association
 Thomas Conner, Atlanta—1957

Representative, Georgia Nursing Association
 Miss Dana Hudson, Atlanta—1957

Representatives, State at Large

Mr. Walter Graefe, Griffin—1957
 Mr. J. J. McLanahan, Elberton—1957
 Mr. Frank A. Smith, Clayton—1956
 H. C. Derrick, Lafayette—1959
 Mr. H. Carson Smith, Lawrenceville—1959

Ex-Officio Members

T. F. Sellers, Director, State Health Department
 Mr. Eugene Cook, Attorney General
 Mr. Alan Kemper, Director, State Welfare Dept.
 Mr. B. E. Thrasher, State Auditor

MAG COUNTY SOCIETY OFFICERS

(This list can be no more correct than your county secretary makes it. Ed.)

- 1-ALTA MAHA**
Edwin Virusky, Baxley, President
J. B. Brown, Baxley, Secretary
- 2-BALDWIN**
Chas. Jordan, Milledgeville, President
Curtis Veal, Milledgeville, Secretary
- 3-BANKS**
- 4-BARTOW**
L. Ross Whatley, Cartersville, President
A. L. Horton, Cartersville, Secretary
- 5-BEN HILL-IRWIN**
Ralph D. Roberts, Fitzgerald, President
W. C. Sams, Ocilla, Secretary
- 6-BIBB**
Thomas L. Ross, Jr., Macon, President
E. C. McMillan, Macon, Secretary
- 7-BLUE RIDGE**
James Burdine, Ellijay, President
Thomas J. Hicks, McCaysville, Secretary
- 8-BULLOCK-CANDLER-EVANS**
W. E. Simmons, Metter, President
John D. Deal, Portal, Secretary
- 9-BURKE**
C. Thompson, Jr., Waynesboro, Secretary
- 10-CARROLL-DOUGLAS-HARALSON**
J. W. Watts, Bowdon, President
D. S. Reese, Carrollton, Secretary
- 11-GEORGIA MEDICAL SOCIETY**
(Chatham)
Ruskin King, Savannah, President
W. W. Osborne, Savannah, Secretary
- 12-CHATTOOGA**
Wm. P. Martin, Summerville, President
Wm. T. Gist, Summerville, Secretary
- 13-CHATTAHOOCHEE**
Harry Hutchins, Buford, President
Fayette Sims, Lawrenceville, Secretary
- 14-CHEROKEE-PICKENS**
B. K. Looper, Canton, President
A. M. Hendrix, Canton, Secretary
- 15-CRAWFORD W. LONG**
Goodloe Erwin, Athens, President
Ronald M. Gustin, Athens, Secretary
- 16-CLAYTON-FAYETTE**
T. J. Busey, Fayetteville, President
Harold Whiteman, Jonesboro, Secretary
- 17-COBB**
Geo. Cauble, Acworth, President
Earl B. Benson, Marietta, Secretary
- 18-COFFEE**
Horace G. Joiner, Douglas, President
Sage Harper, Douglas, Secretary
- 19-COLQUITT**
J. W. McLeod, Moultrie, President
John G. Wells, Newnan, Secretary
- 20-COWETA**
James Bryant, Newnan, President
James H. Powell, Sr., Newnan, Secretary
- 21-DECATUR-SEMINOLE**
F. L. Gibson, Bainbridge, President
M. A. Ehrlich, Bainbridge, Secretary
- 22-DEKALB**
M. F. Simmons, Decatur, President
W. K. Kerr, Chamblee, Secretary
- 23-DOUGHERTY**
C. S. McCall, Albany, President
J. S. Inman, Albany, Secretary
- 24-ELBERT**
Phyllis J. O'Neal, Elberton, President
C. A. Mickel, Jr., Elberton, Secretary
- 25-EMANUEL**
R. G. Brown, Swainsboro, President
R. J. Moye, Adrian, Secretary
- 26-FLINT**
C. E. McArthur, Cordele, President
Perry Busbee, Cordele, Secretary
- 27-FLOYD**
E. S. Brannon, Rome, President
Sam Garner, Rome, Secretary
- 28-FRANKLIN**
S. D. Brown, Jr., Royston, President
E. T. Poole, Lavonia, Secretary
- 29-FULTON**
B. L. Shackleford, Atlanta, President
Tully T. Blalock, Atlanta, Secretary
- 30-GLYNN**
Robt. S. Burford, Brunswick, President
J. M. Hicks, Brunswick, Secretary
- 31-GORDON**
C. K. Richards, Calhoun, President
J. Leroy Rabb, Calhoun, Secretary
- 32-GRADY**
C. K. Singleton, Cairo, President
John A. Ferrence, Whigham, Secretary
- 33-HABERSHAM**
Thos. N. Lumsden, Clarkesville, Pres.
J. J. Arrendale, Cornelia, Secretary
- 34-HALL**
W. C. McCarver, Jr., Gainesville, Pres.
O. T. Ghent, Gainesville, Secretary
- 35-HART**
George T. Harper, Dewy Rose, President
Louis G. Cacchioli, Hartwell, Secretary
- 36-PEACH BELT**
A. Smoak Marshall, Ft. Valley, President
E. Faxton Seay, Marshallville, Secretary
- 37-JACKSON-BARROW**
F. M. McElhannon, Winder, President
C. B. Skelton, Winder, Secretary
- 38-JASPER**
Marvin L. Green, Monticello, President
E. M. Lancaster, Shady Dale, Secretary
- 39-JEFFERSON**
C. Roy Williams, Wadley, President
Geo. S. Pilcher, Louisville, Secretary
- 40-JENKINS**
Q. A. Mulkey, Millen, President
A. P. Mulkey, Millen, Secretary
- 41-LAMAR**
J. H. Jackson, Barnesville, President
S. B. T aylor, Barnesville, Secretary
- 42-LAURENS**
John A. Bell, Jr., Dublin, President
James F. O'Daniel, Dublin, Secretary
- 43-MACON**
44-McDUFFIE
A. G. LeRoy, Thomson, President.
Paul H. Wilson, Thomson, Secretary
- 45-MERIWEATHER-HARRIS**
Hart S. Odom, Greenville, President
J. W. Smith, Manchester, Secretary
- 46-MITCHELL**
D. S. Sowell, Pelham, President
A. A. McNeill, Camilla, Secretary
- 47-MUSCOGEE**
Hugh Bickerstaff, Columbus, President
Robert H. Vaughan, Columbus, Secretary
- 48-NEWTON**
C. B. Palmer, Covington, President
G. G. Tuck, Covington, Secretary
- 49-OCONEE VALLEY**
J. Lee Parker, Jr., Greensboro, President
George Green, Sparta, Secretary
- 50-OCMULGEE**
Wm. R. Baker, Hawkinsville, President
Wm. E. Coleman, Hawkinsville, Secretary
- 51-POLK**
Wm. H. Blanchard, Cedartown, President
Cecil B. Elliott, Cedartown, Secretary
- 52-RABUN**
G. H. Boyd, Jr., Clayton, President
J. C. Dover, Clayton, Secretary
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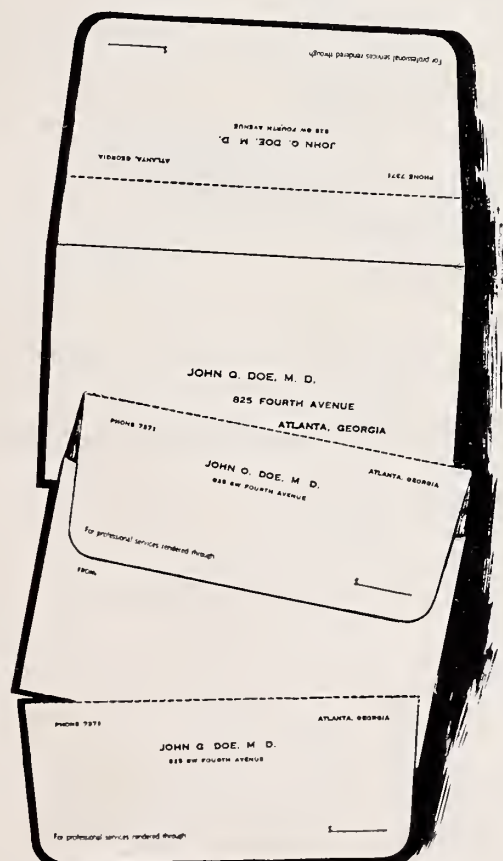
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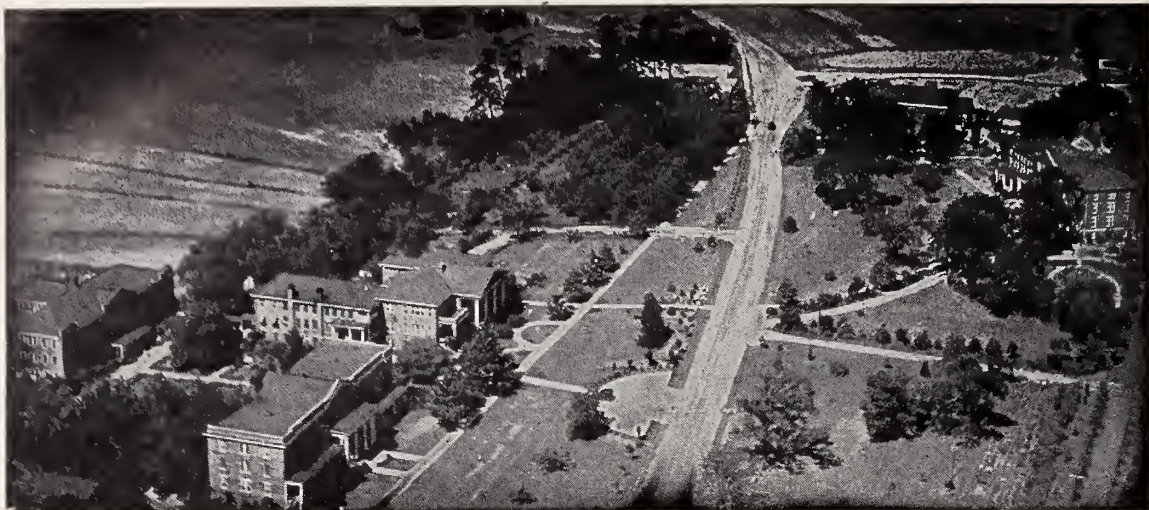
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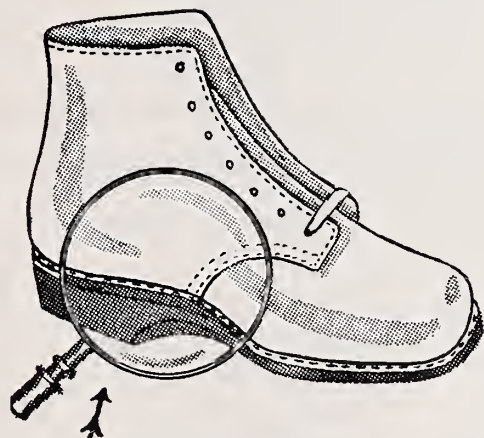
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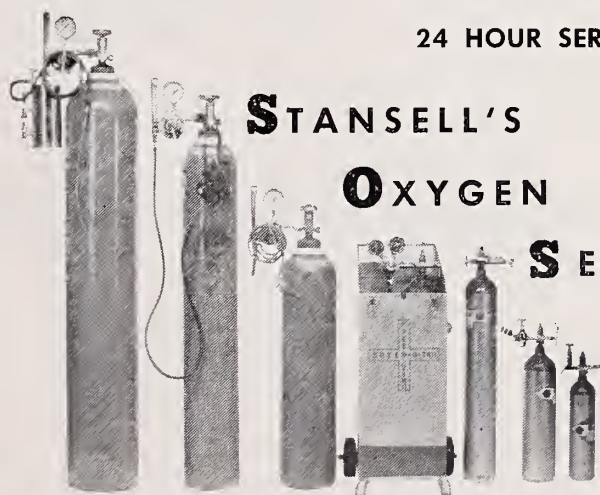
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